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**Therapeutic Milieu Approaches within a High Security
Hospital: A Qualitative Analysis of Patients' Experiences
of Ward-Talking-Groups**



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Doctorate in Clinical Psychology

(D. Clin. Psychol.)

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1. Thesis Abstract

Background: Research has shown that staff-patient relationships within secure forensic services appear to be influenced by an ethos of institutional control, most evident in the tensions of developing meaningful therapeutic relationships while continuing to maintain high levels of security. In an attempt to address the perceived deficits in these relationships, the development of a positive therapeutic milieu was proposed within a high security hospital. Novel therapeutic interventions, known as Ward-Talking-Groups (WTGs), were introduced as a first step towards the development of this milieu. It was also recognised that research exploring the efficacy of psychological interventions for the treatment of psychotic symptoms have exclusively focused on community based settings or general psychiatric hospitals. Although the findings from these reviews have some utility within a forensic psychiatric population, this population also have a number of co-occurring complex needs that inevitably impact on treatment outcomes.

Objective: The primary study aimed to explore in detail patients' experiences of being part of their WTGs. A systematic review was also conducted to review the existing literature regarding the efficacy of psychological interventions for the treatment of psychotic symptoms in individuals with forensic needs.

Methods: For the primary study, semi-structured interviews were conducted with ten male participants detained within a high security hospital. The data was transcribed and analysed using Interpretative Phenomenological Analysis. For the systematic review, using predefined inclusion and exclusion criteria, eight databases were searched, selected journals were hand searched and two grey literature databases were searched to identify relevant studies.

Results: For the primary study, three themes emerged from the data: *Coming together as a unit*, *Liberty Vs. Control*, and *Facing something new*. For the systematic review, eight studies fulfilled the inclusion criteria for review, with relevant information from each study being extracted and tabulated. The identified studies were scored against quality criteria.

Discussion: For the primary study, the findings highlight the importance of patients being able relate to other people within their WTG, with the challenges and benefits of this being at the forefront of participants' minds. Participants described an increased sense of liberty within their WTG, while being acutely aware this was within the context of a high security hospital. Participants' feelings towards the introduction of their WTG appeared to be split; some felt ambivalence towards them, while others were open-minded about them. Reflecting on the introduction of their WTGs, participants shared the view that more information about them was necessary. However, they differed in their approach to seeking this out. For the systematic review, overall findings from the review papers tentatively suggest there is some evidence for the efficacy of psychological interventions in the treatment of psychotic symptoms in individuals with forensic needs. Clinical implications, strengths and limitations, and future research possibilities are outlined for both the empirical study and systematic review.

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3. Systematic Review

Title: The efficacy of psychological interventions for the treatment of psychotic symptoms in individuals with forensic needs: A Systematic Review

Running head title: Psychological therapies in forensic psychiatry

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3.1. Abstract

A systematic review was conducted to explore the efficacy of psychological interventions for the treatment of psychotic symptoms in individuals with forensic needs. Eight databases were searched, selected journals were hand searched and two grey literature databases were searched in an effort to obtain relevant unpublished studies. Eight studies fulfilled the inclusion criteria for review, with relevant information from each study being extracted and tabulated. The identified studies were scored against quality criteria. Overall the findings from the reviewed papers tentatively suggest there is some evidence for the efficacy of psychological interventions in the treatment of psychotic symptoms in individuals with forensic needs.

Keywords: systematic reviews, forensic, psychotic symptoms, intervention, therapies

3.2. Introduction

3.2.1. Current guidelines for the treatment of psychosis

The current recommendations for the treatment of psychosis are oral antipsychotic medication in conjunction with psychological interventions. Cognitive-behavioural therapy (CBT) is currently recognised as the most evidence based intervention for the treatment of psychosis, with family therapy also being recommended where individuals with a diagnosis of psychosis are in close contact with or live with family members (NICE, 2014; SIGN 2013). It is recommended that CBT be delivered over at least 16 planned sessions with these following a treatment manual. Treatment should enable individuals to establish links between their thoughts, feelings or actions and their current or past symptoms and/or functioning. Treatment should also include at least one of the following: monitoring of thoughts, feelings or behaviours with respect to symptoms; promotion of alternative ways of coping with symptoms, and reduction in distress (NICE, 2014).

3.2.2. Efficacy of psychological interventions for the treatment of psychosis

Despite the National Institute of Clinical Excellence (NICE) recommendations that services should offer CBT to all people with psychosis, there continues to be controversy over which psychological interventions are most efficacious in the treatment of psychosis (Turner, Gaag, Karyotaki, & Cuijpers, 2014). Over the past 10 years over 30 trials have compared CBT to treatment as usual or other active interventions, with many endorsing CBT as an effective intervention for improvement of psychotic symptoms (Barrowclough Haddock, Lobban, Jones, Siddle, Roberts, & Gregg, 2006; Pilling, Bebbington, Kuipers, Garety, Geddes, Orbach, & Morgan, 2002; Tarrier & Wykes, 2004; Wykes, Hayward, Thomas, Green, Surguladze, Fannon, & Landau, 2005; Zimmerman, Favrod, Trieu, & Pomini, 2005).

Wykes, Steel, Everitt, and Tarrier's (2008) meta-analysis explored the effect sizes of CBT for psychosis trials. They found overall significant effect sizes for several outcomes, including targeted symptoms (as specified by the researchers of individual studies) ($ES=0.40$); positive symptoms ($ES=0.37$) and negative symptoms ($ES=0.44$). The findings of their meta-analysis were in accordance with earlier meta-analyses in this (Rector & Beck, 2001; Gould, Mueser, Bolton, Mays, & Goff, 2001; Pilling et al, 2002; Pfammatter, Junghan, & Brenner, 2006). area. However, the methodological rigour of their meta-analysis perhaps provides more weight to their findings, as the authors based their assessments on weighted effect sizes, something earlier meta-analyses had not done (Rector & Beck, 2001; Gould, Mueser, Bolton, Mays & Goff, 2001). They also included all eligible trials, with due consideration being given to the methodological variability of studies, other areas not considered in earlier meta-analysis (Pilling et al, 2002; Pfammatter, Junghan & Brenner, 2006). Although their effect size for positive symptoms was smaller than previous meta-analyses, when they compared their findings to Zimmerman et al.'s (2005) smaller, but similarly rigorous meta-analysis, effect size was very similar ($ES=0.35$).

However, Jones, Hacker, Cormac, Meaden, & Irving's (2012) recent meta-analysis, comparing CBT to other psychological interventions for the treatment of schizophrenia, proved unable to report any significant benefit of CBT over other psychological therapies. More specifically, no difference was found in outcomes relevant to positive and negative symptoms of schizophrenia. However, their analysis was limited due to their CBT group also including studies specifically targeting medication compliance, potentially minimising their pooled results for CBT. Lynch, Laws, and McKenna's (2009) meta-analysis compared CBT to active control interventions for the treatment of psychotic symptoms. The pooled effect sizes for positive symptoms favoured CBT. However, this result was found to be moderated by blindness, with effect size in the six blind studies being -0.08 compared to -0.87 in the two

non-blind studies. Blinding researchers to group allocation is recommended when possible to reduce the potential for differential treatment of groups and/or assessment of outcomes. The authors therefore concluded that CBT was no more effective than non-specific comparison interventions. However, there were some criticisms of Lynch et al.'s (2009) methodology, as it was thought to wrongly assume active control interventions' lack specific therapeutic effects: it excluded studies compared with treatment as usual (Kingdon, 2009) and lacked transparent reporting of methods and results (Lincoln, 2010).

Given the limitations of earlier comparative meta-analyses, Turner et al. (2014) felt a further meta-analysis was warranted to provide additional insight into the efficacy of psychological interventions for psychosis. Risk of bias was assessed by using the first four criteria of the Cochrane Collaboration risk of bias tool. Researcher allegiance was assessed and sensitivity analyses were undertaken for robust significant results. Although significant findings were found for CBT, social skills training and cognitive remediation with regards to overall symptoms, with CBT also found to be effective in reducing positive symptoms, significant results were lost after sensitivity analyses. Social skills-training was found to be efficacious in reducing negative symptoms ($g=0.27$) and CBT was also found to be significantly more effective than befriending (i.e. a friendly discussion or social activities, not directly related to symptoms, with a supportive and empathic individual) for overall symptoms ($g=0.42$) and supportive counselling for positive symptoms ($g=0.23$). These findings remained significant after all sensitivity analyses. However, the authors highlight the limited conclusions that can be drawn from their study due to its lack of statistical power, the subjectivity inherent within categorization of studies and their focus on positive, negative and general symptoms. As the interventions under investigation only indirectly target symptoms, the scope of their study did not allow for consideration of efficacy in other domains.

Despite current recommendations, it would be reasonable to conclude from these reviews that the jury is still out with regards to the efficacy of one psychological intervention over another in the treatment of psychosis. However, as it stands, CBT continues to be the most evidence-based intervention for the treatment of psychosis.

3.2.3. The treatment of psychosis in individuals with forensic needs

This evidence base is also applied to the treatment of psychosis in forensic populations. Unfortunately the research supporting these recommendations has generally been conducted in community-based settings or general psychiatric hospitals. Although their findings have some utility within a forensic psychiatric population, typically, this population also have a number of co-occurring complex needs that can inevitably impact on treatment outcomes (e.g. attachment difficulties, substance misuse, cognitive impairment, psychosis, personality disorder) (Elsayed, Al-Zahrani & Rashad, 2010; Forensic Matrix, 2011; Adshead & Aiyegbusi, 2014). It would therefore be useful to be able to draw on research that considers this populations complexity to enable clinicians to make more informed decisions about treatment options for patients within this setting.

However, current research on the efficacy of psychological interventions in forensic psychiatric settings tends to focus on outcomes related to violence recidivism. Duncan, Nicol, Ager, & Dalglish's (2006) systematic review of structured group interventions with mentally disordered offenders found that more than half of the studies reviewed focused on problem solving skills and anger/aggression management interventions. Other studies focused on deliberate self-harm interventions and varying formats of cognitive-behavioural interventions, none of which reported psychotic symptoms as an outcome measure. This focus on the reduction of violence recidivism is understandable given a significant proportion of forensic patients do go on to commit violent offences (Maden, Scott, Burnett, Lewis, &

Skapinakis, 2004; Nilsson, Wallinius Gustavson, Anckarsater, & Kerekes, 2011).

While the need for interventions that reduce outcomes specifically related to violence recidivism is clear and obviously beneficial to forensic patients and the community more generally, the efficacy of psychological interventions for the treatment of psychotic symptoms in this population appears to be an underrepresented area. It is hoped that a systematic review of the current literature will provide more information about the efficacy of these interventions in the treatment of psychotic symptoms with this population. Extensive literature searched found no similar reviews in this area.

3.2.4. Aim of the Review

The purpose of this review was to systematically review the existing literature regarding the efficacy of psychological interventions for the treatment of psychotic symptoms in individuals with forensic needs.

3.3. Method

3.3.1. Inclusion and Exclusion Criteria

Population: Inclusion criteria required study participants to be adults aged 18-65 years with a diagnosis of psychosis and co-occurring forensic needs. Participants could be those detained within hospital (described as forensic inpatients) or forensic outpatients being managed in the community or prison settings. Studies whose participants had an intellectual disability (ID) were excluded due to the likelihood of adaptations being made to the intervention for use with an ID population.

Interventions: Studies using any form of psychological intervention were included. This included but was not restricted to Cognitive Behaviour Therapy (CBT), Psycho-education and Family Therapy (FT).

Outcome measures: Inclusion criteria required psychotic symptomatology to be outcome measured. The symptoms of psychosis are typically divided into two categories, 'positive' and 'negative' symptoms. Positive symptoms can include delusions (rigid or falsely held beliefs) and hallucinations (perception in the absence of stimulus). Negative symptoms can encompass lethargy, poverty of speech, social withdrawal, apathy and self-neglect. Each individual will have a unique combination of symptoms and experiences (NICE, 2014). It was acknowledged that within forensic research, primary outcomes are more likely to be focussed around risk. Therefore all studies measuring psychotic symptoms were considered, whether they were the primary outcome or not. Studies that did not measure outcome in either of these domains, or did not refer to the use of outcome measures, were excluded.

Study design: Randomised control trials (RCTs), other controlled trials and cohort studies were included. Case series were excluded given the likelihood of bias due to limited participant numbers. Single case studies were also excluded due to bias and issues around generalising results. Studies that appeared to use duplicate data were also excluded.

Language: The reviewer did not have access to translation resources; therefore searches were limited to English language studies only.

3.3.2. Literature Search Strategy

Prior to conducting this review the Centre for Reviews and Dissemination (CRD) database was searched to ascertain a similar review had not recently been conducted. No similar reviews were found. The following electronic databases were searched from start dates to 9th June 2014: Medline (1946-2014), EMBASE (1980-2014), ERIC (1965-2014), CINAHL Plus with Full Text (1937-2014), PsycINFO (1930-2014), Psychology and Behavioral Sciences Collection (1971-2014), ScienceDirect (1823-2014) and Cochrane Library (1898-2014).

The thesaurus and 'map terms' functions within databases, as well as key terms from related reviews and discussion with the second author of this review were utilised when generating search terms. These were: secure setting* OR secure hospital* OR special hospital* OR forensic psychiatry OR forensic* OR prison* OR prison nurs* OR mentally ill offender* OR mentally disordered offender* OR forensic nurs* OR community forensic mental health **AND** psychos* OR psychotic disorder* OR schizophrenia* OR schizoaffective disorder* OR delusion disorder* OR bipolar disorder* OR bipolar illness* OR manic depress* OR psychotic depress* OR depression with psychotic features OR depressive psychos* **AND** psychosocial intervention* OR cognitive therap* OR cognitive behavioural therap* OR cognitive behaviour therap* OR behaviour therapy OR CBT OR family intervention* OR family therap* OR patient education* OR psychoeducation OR psycho-education OR psycho-educational family intervention* OR psychoeducational family intervention* OR group psychoeducation OR group psycho-education* OR interpersonal and social rhythm therap* OR IPSRT OR interpersonal therap* OR interpersonal psychotherap*.

The search of the 8 databases yielded 301 papers. In addition, a hand search of four relevant journals was carried out from start dates until June 2014. These were: British Journal of Forensic Practice (1999-2012)/Journal of Forensic Practice (2012-2014); The Journal of Forensic Psychiatry & Psychology (1990-2014); Behavioural & Cognitive Psychotherapy (1975-2014) and International Journal of Law and Psychiatry (1978-2014). Internet searches for grey literature were also performed via the British National Bibliography for Report Literature (www.bl.uk) and System for Information on Grey Literature in Europe (www.opengrey). The Google Scholar search engine was also used to screen for relevant papers. These methods of searching highlighted a further 26 titles of potential interest, giving a total of 327 papers. Removal of duplicates left 260 papers. On review of titles and abstracts, 239 papers were excluded as it was evident they did not meet inclusion criteria. This left 23

papers to be read in full. Of these 23, a further 15 papers were excluded as they did not meet the inclusion criteria and/or further information was inaccessible. Two authors were contacted to establish whether their descriptive papers have been written up as research. One author replied but no further write up had been completed. This left a total of 8 papers to be included in the review. The reference lists of the included papers were then searched but no further papers met the inclusion criteria. This culminated in a total of 8 papers to be included in the systematic review. See figure 3.1 for a flow diagram depicting the literature search strategy and selection process.

3.3.3. Assessment of Quality of Included Studies

Centre for Research and Dissemination (CRD) have published specific guidance for undertaking systematic reviews in health care. The document describes several areas that should be considered in quality assessment of any study. These are: appropriateness of study design to the research objective, risk of bias, other issues related to study quality, choice of outcome measure, statistical issues, quality of reporting, quality of the intervention and generalisability (CRD, 2008). The reviewer also browsed published reviews that used this document as a guide when developing criteria. Due to similarities in review question and participant population, specific guidance was taken from Ross, Quayle, Newman, and Tansey (2013) when constructing criteria for this review.

A total of 12 criteria were developed with these being used to assess the 8 studies included in this review. The scoring for each criterion is as follows: Well covered = 3; Adequately Addressed = 2; Poorly Addressed = 1; Not Addressed = 0; Not Reported = 0 and Not Applicable = 0. A total score is also given based on the scoring for each criterion. A second marker was recruited to ensure inter-rater reliability. Two papers (25% of included studies) were independently rated. There was a Kappa-coefficient for overall agreement of

0.75, demonstrating adequate inter-rater agreement (Randolph, 2008). Markers discussed differences in criteria ratings, with amendments being made where appropriate.

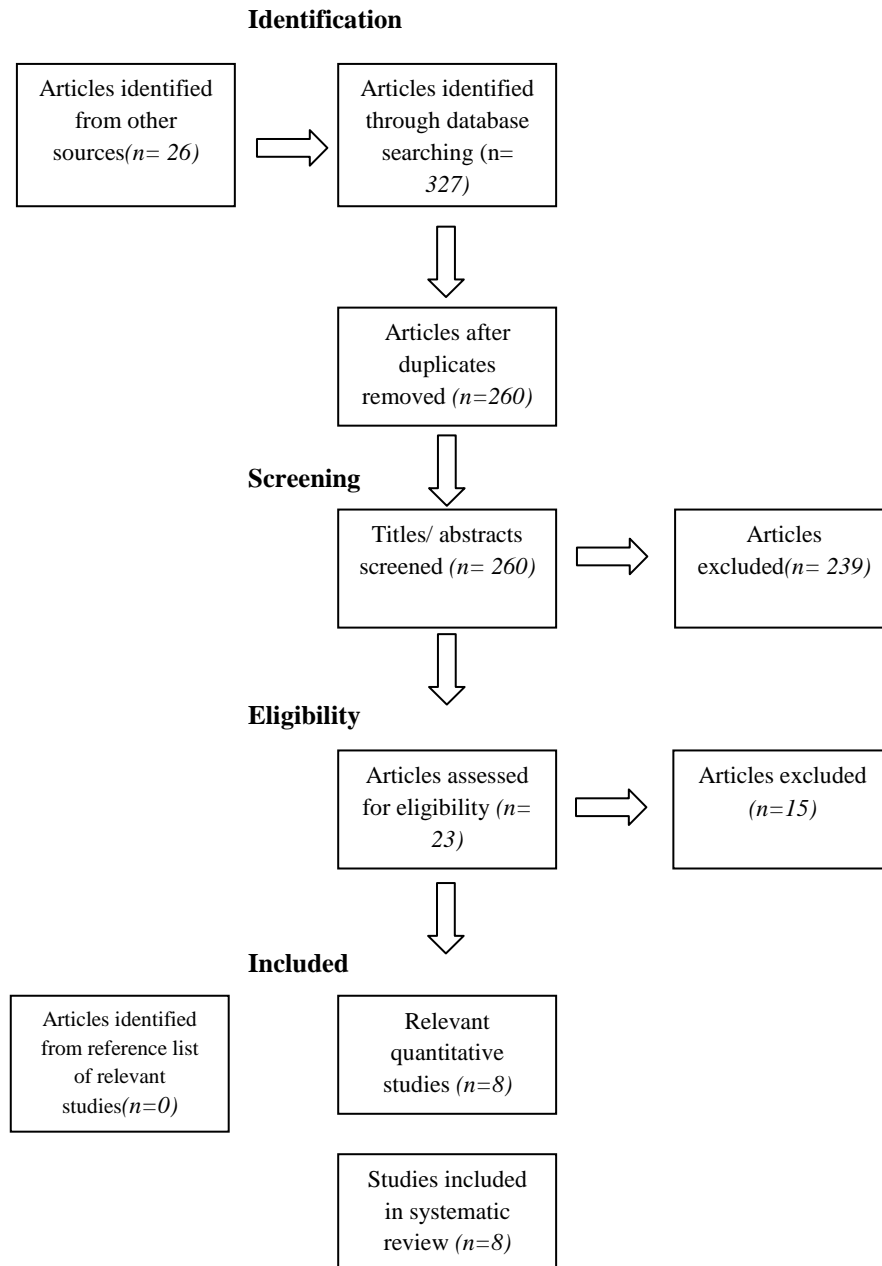


Figure 3.1: Flow diagram depicting the literature search process

3.4. Results

3.4.1. Characteristics of Included Studies

A summary of the 8 articles included in this review are presented in Table 3.1. See appendix B for a table of the excluded studies and the reasons for this. Due to the heterogeneous nature of the studies identified, a narrative synthesis was considered more appropriate than a meta-synthesis. There are five experimental studies and three observational studies included in this review. Of the experimental studies, two were small RCTs (Aho-Mustonen, Tiihonen, Repo-Tiihonen, Ryynanen, Miettinen, & Raty, 2011; Walker, Tulloch, Ramm, Drysdale, Steel, Martin, MacPherson, & Connaughton, 2013) and three were pre- and post-intervention studies (Williams et al, 2014; Laithwaite et al, 2007; Ferguson, Conway, Endersby, & MacLeod, 2009). The observational studies adopted a cohort design (Hornsveld & Nijman, 2005; Walker, Connaughton, Wilson, & Martin, 2012; Naughton, Nulty, Abidin, Davoren, O'Dwyer, & Kennedy, 2012). For the purposes of comparison, the studies have been grouped according to psychological intervention under investigation.

Table 3.1: Summary of included studies

	Number of participants	Participants	Intervention	Outcome measures	Key findings
Aho-Mustonen et al. (2011) Finland	39 (35 men, 4 women) 19-Psychoeducation 20-TAU	Forensic inpatients	RCT- Psychoeducation programme- group Duration: 8 weeks Sessions: 8 x 45-60 mins Discipline(s) of facilitator(s): Not reported Fidelity checks: Present	KASQ-knowledge about schizophrenia and its management SUMD-insight CRS-compliance The Drug Attitude Inventory-10-attitudes towards medication BPRS-symptoms and signs of mental state and their change over time NOSIE-30-ward behaviours Finnish version of BDI-II-depression RSE- self-esteem 15D-health related quality of life PSQ-stigma if mental illness	Significant improvements in self-esteem post-treatment ($p=.03$) when compared to TAU. Not maintained at 3-month follow-up. Positive treatment effect found for knowledge about illness, with this reaching significance at 3-month follow-up ($p=.04$). No significant improvements found in insight or psychotic symptoms post-treatment (SUMD: $p=.67$; BPRS: $p=.57$) or at 3-month follow-up (SUMD: $p=.09$; BPRS: $p=.76$). Possible adverse effect was increase in irritability subscale on NOSIE-30 for treatment group.
Ferguson et al. (2009) UK	14 (male)	Forensic inpatients	Well-being intervention-group Duration: 6 weeks Sessions: 6 (time frame not reported) Discipline(s) of facilitator(s): Not reported Fidelity checks: Present	PANAS- affective components of wellbeing SWLS- cognitive components of wellbeing FTT- positive and negative cognitions concerning the future HADS- anxiety and depression BHS- hopelessness NSS- negative symptoms of schizophrenia	Significant improvement in negative symptoms ($p<.001$), negative affect ($p<.01$), satisfaction with life ($p<.05$), positive future thinking ($p<.001$), depression ($p<.05$) and hopelessness ($p<.05$). No other outcomes showed significant change over the course of treatment. Significantly lower levels of depression were not maintained at 2-month follow-up ($p=.06$). All other improvements were maintained at follow-up.
Hornsveld & Nijman (2005) The Netherlands	41 (male) 25 began, 16 completed -CBT 16-TAU	Forensic inpatients	CBT programme called 'Psychotic Disorders'-group Duration: 1 year Sessions: 56 x 90 mins Discipline(s) of facilitator(s): Not reported Fidelity checks: Not	REHAB- general functioning MI Observation scale- cooperative behaviour, social skills, domestic skills, anti-social behaviour, positive & negative coping skills. PANSS-positive and negative symptoms and general psychopathology SIG - social anxiety and frequency of	Statistically significant improvement found in social skills compared to TAU ($p<.05$). Increase in positive coping behaviour when compared to TAU, but did not reach significance ($p=.098$). Decrease in negative coping behaviours when compared to TAU ($p<.05$). No significant decrease in PANSS total scores or negative symptoms ($p=0.06$). No significant change in social

			reported	social behaviour	anxiety of social behaviours.
Laithwaite et al. (2007) UK	15 (male)	Forensic inpatients	Self Esteem Programme-group Duration: 10 weeks Sessions: 10 x 2 hours 30 minutes Discipline(s) of facilitator(s): Clinical Psychologist, Clinical Nurse Specialist in CBT, Assistant Psychologist Fidelity checks: Present	RSE- self-esteem RSCQ-self esteem SIP-AD-self esteem PANSS PSYRATS-delusions and auditory hallucinations BDI-II-depression	Significant improvements in self-esteem over the course of the group intervention (RSE= $p<.05$; SIP-AD= $p<.01$), with some effects maintained at 3 month follow-up (RSE= $p<.05$). Significant overall effect on the delusions rating scale of the PSYRATS ($p<.05$). Improvements in depressed mood also found (BDI-II: $p<.05$; PANSS depression scale: $p<.05$). This effect was maintained at follow-up for the BDI-II ($p<.05$) but not the PANSS depression scale.
Naughton et al. (2012) Republic of Ireland	19 (male) 11 (MCT) 8 (waiting list controls)	Forensic inpatients	Metacognitive training (MCT)- group Duration: 8 weeks Sessions: 16 (time frame not reported) Discipline(s) of facilitator(s): Psychiatrist, Clinical Nurse Specialist Fidelity checks: Present	PANSS GAF-general functional competence MacCAT-T-functional mental capacity in relation to treatment MacCAT-FP- functional mental capacity in relation to fitness to plead DUNDRUM-1- need for various levels of therapeutic security and appropriateness for admission to a secure forensic psychiatric hospital HCR-20-structured professional judgement tool for identifying risk factors for violence	No significant changes in psychotic symptoms compared with the waiting list comparison group ($p=>.2$). Significant improvements were found in the intervention group for general functional competence ($p=.019$) and the understanding subscale ($p=.011$) of the Mac-CAT-T. Correlations of outcome measures with the number of treatment sessions attended for patients in both groups, showed significant improvement in the understanding ($p=.004$) and reasoning scores ($p=.02$) of the Mac-CAT-T. The number of treatment sessions attended also significantly improved GAF scores ($p=.008$).
Walker et al. (2012) UK	48 (male) 28-Psychoeducation 20-TAU	Forensic inpatients	Psychoeducation programme called 'Coping with Mental Illness'- group Duration: 11 weeks	UMQ-knowledge about antipsychotic treatment PANSS SAI-insight Measures developed: FAKT - measure of patient understanding of	Statistically significant improvement in knowledge about illness (FAKT: $p<.01$) and understanding of medication immediately post-treatment (UMQ: $p<.01$) and at 6-month follow-up (FAKT: $p<.01$; (UMQ: $p<.05$). Compared to TAU at 6-

			Session: 22 x 1 hour Discipline(s) of facilitator(s): Consultant Nurse, Consultant Psychiatrist Fidelity checks: Present	symptoms, management of illness and legal issues using semi-structured questionnaire	month follow-up, statistically significant difference maintained for both outcomes (FAKT: $p=.012$; UMQ: $p=.050$). Statistically significant improvement in insight at 6-month follow-up when compared to TAU ($p=.039$). Treatment group showed a statistically significant improvement in positive symptoms at 6-month follow-up ($p=.042$).
Walker et al. (2013) UK	81 (79 male, 2 female) 46-Psychoeducation 35-TAU	Forensic inpatients	RCT – Psychoeducation programme called 'Coping with Mental Illness'-group Duration: 11 weeks Sessions: 22 x 1 hour Discipline(s) of facilitator(s): Consultant Psychiatrist, Clinical Nurse Specialist or 'suitably qualified alternatives' Fidelity checks: Present	SAI PANSS CDSS-depression SQLS-R4-quality of life BEST Index-social behaviour FAKT	Significant improvement in knowledge of illness found for treatment group ($p<.01$). There was evidence of some improvement in: insight ($p=.13$), depression ($p=.320$), positive symptoms ($p=.17$), negative symptoms ($p=.17$); general psychopathology ($p=.14$), social behaviour ($p=.42$) and quality of life ($p=.47$), but did not reach significance. However, the empathy subscale of the BEST Index showed significant improvement ($p=.029$). Improvements maintained at 6 month follow-up on all but social behaviour.
Williams et al. (2014) UK	47 (male) 30 - CBT (27 completed) 17- TAU	Forensic inpatients	CBT group with 1.1 CBT sessions Duration: 35 weeks Sessions: 35 x 1.5 hours Discipline(s) of facilitator(s): Not reported Fidelity checks: Present	SAPS-positive symptoms SANS-negative symptoms PSYRATS DASS-depression, anxiety and stress IIP-difficulties in interpersonal relationships	Statistically significant improvement in negative symptoms when compared to TAU ($p=.028$). Moderate effect size differences found for positive symptoms on the SAPS, but these were not statistically significant when compared to TAU ($ES=.77$). Conflicting findings reported on the PSYRATS as no improvement in positive symptoms were found. No statistically significant differences were found between groups on other measures.

**See Appendix C for notes on table 3.1*

3.4.2. Summary of Results

3.4.2.1. Group Psychoeducation

Aho-Mustonen et al. (2011), Walker et al. (2012) and Walker et al. (2013) investigated the efficacy of group psycho-education among forensic patients with a diagnosis of psychosis, detained within a high-security hospital. Aho-Mustonen et al.'s (2011) exploratory RCT, being the first of its kind, was designed to explore justification for future studies while identifying relevant outcomes for further clinical trials. Walker et al.'s (2012) pilot study also explored the efficacy of group psycho-education for this client group, using a number of outcome measures. Although improved patient knowledge about mental health, effects of medication and legal status was their primary hypothesis, the authors also hypothesised that improvement in these areas would result in an improvement in psychotic symptoms and insight. Walker et al. (2013), informed by the results of the Walker et al.'s (2012) pilot study, conducted a multi-site RCT exploring insight and the impact an improvement in insight would have on a number of outcomes, including psychotic symptoms. The results of these studies are summarised below.

Aho-Mustonen et al. (2011) found no significant improvements in psychotic symptoms (BPRS) post-treatment or at three-month follow-up. With regards to other outcomes, the intervention group showed significant improvements in their self-esteem and insight over the course of treatment, when compared to the TAU group. However, this was not maintained at three-month follow-up. There was also a positive treatment effect found for knowledge about illness, with this reaching significance at three-month follow-up.

Similarly, Walker et al.'s (2012) intervention group showed a statistically significant improvement in knowledge about illness immediately post-treatment and at six-month follow-up. This was also the case for knowledge about effects of medication. When compared to the TAU group at six-month follow-up, this statistically significant difference

was maintained for both outcomes. Due to the study hypotheses, Walker et al. (2012) only measured other outcomes pre- intervention and at six month follow-up. At this point they found a statistically significant improvement in insight and positive symptoms (PANSS) in the treatment group, when compared to TAU. There were no statistically significant improvements found in negative or general PANSS scores for the treatment group or TAU group PANSS scores at six months follow-up.

Walker et al.'s (2013) RCT found some evidence of improvement in positive symptoms, negative symptoms, general psychopathology, insight, depression, quality of life and social behaviour, immediately post-treatment, but these did not reach significance when compared to TAU. There was a statistically significant improvement in knowledge of illness and an unexpected significant improvement in empathy for the treatment group (as measured by a the empathy subscale of the BEST index), when compared to TAU. Improvements were maintained at 6-month follow-up on all outcomes but social behaviour. The authors highlight that improvements might have reached significance if their sample size had not been reduced from 94 to 81 due to errors associated with random allocation, resulting in a lack of statistical power.

3.4.2.2. CBT (or variant thereof) group interventions

Hornsveld & Nijman, (2005), Laithwaite et al. (2007), Naughton et al. (2012) and Williams et al. (2014) investigated the efficacy of CBT group interventions among forensic patients with a diagnosis of psychosis, detained within a secure hospital setting. Hornsveld & Nijman's (2005) cohort study did not state specific study objectives but psychotic symptoms were outcome measured. Williams et al. (2014), although using a controlled trial design, also explored the efficacy of a cognitive-behavioural group programme on the treatment of psychotic symptoms, as well as interpersonal problems with this client group. Laithwaite et

al. (2007) explored the efficacy of a CBT group intervention targeting self-esteem on the treatment of low self-esteem and positive symptoms of psychosis. Finally, Naughton et al. (2012) explored the effects of MCT on psychotic symptoms and mental capacity.

Hornsveld & Nijman's (2005) evaluation found no significant changes in psychotic symptoms (PANSS). There were no significant improvements in general functioning in the intervention or TAU group. A statistically significant improvement was found in the social skills and negative coping subscale of the MI Observation scale for the intervention group, when compared to TAU group. Although there was an increase in positive coping behaviour for the intervention group, when compared to the TAU group, this did not reach significance. There were no significant changes in social anxiety or frequency of social behaviours for the treatment group. However, the authors suggest considerable caution be used when interpreting these findings as the sample size was small. This sample was reduced further as only half of the intervention group were outcome measured of PANSS and SIG as the treatment program was at an advanced stage when they were introduced.

William et al.'s (2014) controlled effectiveness trial found a statistically significant improvement in negative symptoms for the intervention group, when compared to TAU. Although there was a trend towards a reduction in positive symptoms when compared to TAU, this was not statistically significant. However, there were conflicting findings reported on the PSYRATS as no improvement in positive symptoms was found. With regards to other outcomes, no statistically significant differences were found between groups. However, the intervention group did report improvement in depression and anxiety compared with TAU group, which reported an increase in these areas. The intervention group also reported an increase in stress but this was only minor and more so when compared to TAU. Finally, the intervention showed an overall reduction in reported interpersonal problems.

Laithwaite et al.'s (2007) pilot study found no significant improvements in positive or negative symptoms as measured by the PANSS, immediately post-treatment. Outcomes for the PSYRATS showed a significant improvement in delusions, with specific effects being found between baseline and mid-treatment. There was no significant change in auditory hallucinations, as measured by the PSYRATS. Significant improvements were found in self-esteem on the RSE and the self-esteem and self image components of the SIP-ID. These improvements were maintained at three-month follow-up for the RSE but not the SIP-AD. No significant effects were found on the third measure of self-esteem. A significant improvement in depression was reported on the BDI-II and the PANSS depressions scale. These improvements were maintained at 3-month follow-up for the BDI-II but not the PANSS depression scale.

Naughton et al.'s (2012) study found no significant changes in psychotic symptoms compared with the waiting list comparison group. Significant improvements were found in the intervention group for general functional competence (GAF) and the understanding subscale of the Mac-CAT-T. When correlating changes in outcome measures with the number of treatment sessions attended for patients in both groups, there was a significant improvement in the understanding and reasoning scores of the Mac-CAT-T. The number of treatment sessions attended also significantly improved GAF but not PANSS scores.

3.4.2.3. Well-being group intervention

Ferguson et al.'s (2009) study found a significant improvement in negative symptoms of psychosis. They also found significant improvements in negative affect, satisfaction with life, positive future thinking, depression and hopelessness. No other outcomes showed significant change over the course of treatment. Significantly lower levels of depression were not

maintained at two-month follow-up ($p=.06$). All other improvements were maintained at follow-up.

3.4.3. Summary across all studies

There were a total of 304 participants across all studies. Five studies were undertaken in the UK with the other three being conducted in the Republic of Ireland, Finland and the Netherlands. Although the studies varied with regards to design, primary outcomes, and the presence or absence of a follow-up period; four studies reported significant reductions in psychotic symptoms following a psychological intervention. Of the studies that did not report significant changes in psychotic symptoms, two studies demonstrated a trend in that direction. The final two studies that did not report a change in psychotic symptoms, demonstrated improvements in other outcomes, often important when considering long-term outcomes for individuals with psychosis. All studies were limited due to small sample sizes, making it difficult to generalise findings to the wider forensic psychiatric population.

3.4.4. Quality of included studies

See table 3.2 for quality ratings for each of the studies included in this review. The rating scale used should not be considered an exact comparative measure; however, it does aid in assessing the relative methodological strengths of each study. For example, Aho-Mustonen et al. (2011) and Walker et al. (2013) are considered to be the methodologically strongest studies, with all other studies being of average methodological quality.

Table 3.2: Quality rating for included studies

	Randomisation	Concealment	Attrition	Follow-up	Outcome measures	Measure relevance	Power	Analysis	Reporting quality	Intervention definition	Fidelity	Routine	Overall 'score' (/36)
Aho-Mustonen et al. (2011)	AA	WC	WC	AA	AA	WC	NR	WC	WC	WC	WC	WC	30
Walker et al. (2013)	WC	AA	WC	WC	PA	AA	NA	WC	WC	AA	PA	WC	26
Naughton et al. (2012)	NA	NA	WC	NA	PA	WC	NR	AA	WC	WC	WC	WC	21
Ferguson et al. (2009)	NA	NA	WC	PA	AA	WC	NR	WC	AA	AA	AA	WC	21
Laithwaite et al. (2007)	NA	NA	WC	AA	PA	WC	NR	AA	AA	WC	AA	WC	21
Walker et al. (2012)	NA	NA	NA	WC	PA	WC	NR	AA	WC	WC	AA	WC	20
Williams et al. (2014)	NA	NA	WC	NA	PA	WC	NR	WC	AA	WC	AA	WC	20
Hornsveld & Nijman (2005)	NA	NA	PA	NA	PA	WC	NR	NR	PA	WC	PA	WC	13

3.5. Discussion

3.5.1. General findings

All studies included in this review had small sample sizes, therefore it is necessary to interpret findings cautiously. Four of the eight studies reviewed found significant improvements in psychotic symptoms (positive and/or negative symptoms) (Walker et al., 2012; Laithwaite et al., 2007; Williams et al., 2014; Ferguson et al., 2009). However, these results are tentative as one study only reported pre- and post-outcomes (Williams et al., 2014), with another only measuring psychotic symptoms at pre-intervention and six month follow-up (Walker et al., 2012). Although Walker et al.'s (2012) outcome collection points are in accordance with their study aims, it leaves the reader unable to establish at which point the improvements reported in their study were achieved and whether these increased/decreased in significance post-intervention. Also, the findings in Laithwaite et al.'s (2007) were inconsistent, in that they found significant reductions in delusions using the PSYRATS but no significant changes in psychotic symptoms using the PANSS. Although improvements were maintained at follow-up in the two other studies (Laithwaite et al., 2007; Ferguson et al., 2009), follow-up periods were relatively short (two and three months respectively).

Of the studies that did not find significant changes in psychotic symptoms, two studies found a trend towards improvements (Walker et al., 2013; Hornsveld & Nijman, 2005). Walker et al. (2013) also included a six-month follow-up period in their RCT, where improvements were maintained. Unfortunately both studies lacked statistical power due to high dropout rates/loss to follow-up (Hornsveld & Nijman, 2005; Walker et al, 2013) and errors during random allocation (Walker et al, 2013).

Measurement of psychotic symptoms in Hornsveld and Nijman's (2005) study was also introduced at an advanced stage in the treatment program, resulting in only half of the

treatment group being administered pre- and post-outcome measures. Naughton et al. (2012) and Aho-Mustonen et al. (2011) found no differences in psychotic symptoms post-intervention compared to their control groups. However, their interventions demonstrated improvements in other outcomes, often important when considering long-term outcomes for individuals with psychosis.

3.5.2. Strengths and limitations of studies

With regards to the quality criteria, the studies' reporting of the intervention process, including the intervention being well defined, delivered in a way considered routine, and being assessed with relevant measures, were considered to be strengths for all included studies. Quality of reporting and reporting and acceptability of attrition rates were also considered to be a relative strength of the studies. An exception was Hornsveld and Nijman's (2005) study, which scored poorly on quality of reporting using the STROBE guidelines. However, it is important to note these guidelines were published after Hornsveld and Nijman's (2005) study which impacts on the applicability of the criterion in this case.

Hornsveld and Nijman (2005) also reported significant drop out rates. This is likely to have significantly skewed the study results. Due consideration should be given to attrition rates within secure forensic settings. Within these settings attending psychological therapies is considered part of patients' care and treatment, with this being inevitably linked to progress towards lower levels of security. Attendance at therapies may be motivated by this and/or improvements in mental health. Therefore, scoring highly on this criterion may not necessarily be reflective of engagement in treatment.

As there were only 2 RCTs eligible for inclusion in this review (Aho-Mustonen et al., 2011 & Walker et al., 2013) the randomisation and concealment criteria were only used with these studies. As RCTs are regarded as the most robust methodology, studies using this

design are arguably of higher quality and therefore scored more highly on the predefined quality criteria. However, all papers included in this review used forensic inpatient populations. The issues around reduced recruitment potential in this area makes it difficult to conduct an RCT. Therefore, these studies should be considered rare opportunities to conduct methodologically robust research, rather than necessarily placing less value on non-RCT studies.

The quality of the included studies was compromised for several reasons. For example, only one study reported a power analysis (Walker et al., 2013), but unfortunately numbers could not be met due to errors during random allocation. For all other studies the sample size required pre-intervention to obtain a medium effect size was unknown. Participant numbers were also very small for some studies (Ferguson et al., 2009; Laithwaite et al., 2007) and generally low for all studies. This might be due to the fact that all but one study (Walker et al., 2013) recruited from only one secure setting, therefore limiting recruitment potential. Low sample sizes could also reflect the challenge of recruiting participants in this population. There were also no follow-up periods for three studies (Naughton et al., 2012, Williams et al., 2014; Hornsvelt & Nijman, 2005), with these being relatively short in other studies (i.e. 6 months or less). Therefore the longevity of the improvements found is unclear.

Due to the diversity of the studies reviewed, it is difficult to draw conclusions about the efficacy of treatment with regards to the quality of each study. The methodologically strongest studies (Aho-Mustonen et al., 2011; Walker et al., 2013) found no significant differences in psychotic symptoms at post-treatment or follow-up. However, this may be explained by the fact that both were psychoeducational interventions, not directly targeting psychotic symptoms, as they demonstrated significant differences in outcomes directly associated with the aims of their intervention.

All other studies were considered to be of moderate quality, four of which found significant improvements in psychotic symptoms (Ferguson et al., 2009; Laithwaite et al., 2007; Walker et al., 2012; Williams et al., 2014). Two of these interventions used a CBT framework and were designed to target psychotic symptoms directly. The others were a well-being (Ferguson et al., 2009) and psychoeducational intervention (Walker et al., 2012) not directly targeting psychotic symptoms. However, Walker et al.'s (2012) study only outcome measured psychotic symptoms at 6-month follow-up. Therefore it is impossible to know whether the improvement is attributable to the intervention or due to improvement in other areas (e.g. knowledge about illness). These findings are consistent with Turner et al.'s (2014) meta-analysis which found that patterns of efficacy are consistent with the specific aims of an intervention. However, their finding that CBT is more efficacious in the reduction of positive symptoms was only partially supported by Laithwaite et al. (2007). Their study found a reduction in delusions, as measured by the PSYRATS, but results were inconsistent, with no significant difference being found on the PANSS. In contrast, Williams et al. (2014) found a reduction in negative symptoms of psychosis. While there was an improvement in positive symptoms, these were not statistically significant when compared to TAU.

Naughton et al. (2012) and Hornsveld and Nijman (2005) also found no significant difference in psychotic symptoms post-treatment. Although the studies used a CBT framework (or a variant thereof) they had very low sample sizes (i.e. 11 and 16 in the treatment groups). Therefore they are not likely to provide the statistical power necessary to accurately reflect the efficacy of these interventions. In fact, all included studies had low sample sizes, with only one study (Walker et al., 2013) providing a power calculation. Unfortunately their sample was later reduced due to loss to follow-up and errors in random allocation.

A common difficulty with RCTs is participant noncompliance and missing outcomes (Gupta, 2011). As discussed earlier, Walker et al.'s (2013) study experienced significant loss to follow-up. Noncompliance should be considered in all RCTs, but even more so in forensic populations, where motivation to engage could differ from the goals of the intervention being administered. This has the potential to increase the risk of participants not complying with instructions. Intention-to-treat analysis (ITT) is considered a potential solution to these problems. However, the RCTs included in this review did not conduct ITT. The addition of ITT would have been likely to improve the quality of these studies as it would have maintained the prognostic balance achieved by random allocation and produced an unbiased estimate of treatment effect. Unfortunately, when noncompliant participants or drop-outs are excluded from the final analysis, it has the potential to create prognostic differences between groups. Furthermore, participant noncompliance and drop-outs may be due to response to treatment (Wertz, 1995). Finally, ITT also maintains the original sample size. The removal of noncompliant participants or drop-outs can significantly reduce sample size, leading to reduced statistical power (Wertz, 1995).

Another consideration when evaluating the quality of a study is the use of process measures. The studies included in this review used symptom outcome measures but did not include process measures. Within a forensic in-patient setting, there are numerous factors such as therapist characteristics, clients' perceptions of the therapist, therapeutic alliance and features of the group climate, that are associated with the effectiveness of treatment (Marshall & Burton, 2010). Marshall and Burton's (2010) literature review found that all of the above processes were critical to achieving the aims of the program, over and above techniques associated with specific interventions. This suggests therapists should be actively attending to these processes during intervention, with these also being considered when measuring the efficacy of treatments.

3.5.3 Strengths and limitations of review

Efforts were made to reduce publication bias by searching grey literature databases to obtain any unpublished work that could be relevant to this review. The reviewers also attempted to reduce the potential for subjective bias in methodological analysis by having a percentage of papers independently rated by a second marker. This produced a high level of inter-rater reliability. However, due to limited resources only 25% of papers were rated by a second rater, leaving a considerable proportion of not checked for inter-rater reliability. The heterogeneity of the studies included in this review is considered to be its greatest weakness, in terms of the focus of the studies and the interventions used. Due to the limited research published in this area, it was not possible to limit the scope of this review to only studies with a primary outcome of psychotic symptom improvement. It is therefore inevitable that the emphasis for some interventions would not be on improvement of psychotic symptoms. This therefore limits our ability to draw conclusions about the effects found. The interventions included were also diverse, limiting our ability to draw conclusions about the differences between therapeutic models and modalities.

3.5.4. Implications for further research

During the literature search process of this review it was noted that the majority of studies exploring the efficacy of psychological interventions had outcomes relating to violence recidivism. Given the onus on forensic mental health services to protect the public, as well as care for their patients, this finding is unsurprising. This is likely to be a reflection of demand for positive outcomes in this area, rather than a lack of work being undertaken in relation to symptom improvement in clinical practice. Of the studies included in this review, only two had a primary outcome of psychotic symptom reduction. When we consider that, with a non-forensic population, over 30 trials have been conducted in the last decade comparing CBT to

TAU and other therapeutic modalities in the treatment of schizophrenia, many of which have named CBT as an effective treatment to reduce psychotic symptoms, it highlights the need for further research in this area.

3.5.5. Implications for clinical practice

Taking into consideration the limitations of this review, it does provide some evidence for the efficacy of psychological interventions for the treatment of psychotic symptoms in individuals with forensic needs. There is a need for further research in this area with a primary focus on symptom improvement. Such studies should be on a larger scale and would benefit from being conducted across forensic services to ensure generalisability of findings to the wider forensic psychiatric population. It is felt this would reduce the issues around heterogeneity that the reviewers found when conducting this review. This would allow for future reviews to draw more meaningful conclusions about the efficacy of psychological interventions for symptom improvement with this population and give some guidance as to what interventions are most effective with this challenging client group.

3.6. References

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4. Research Article

Title: Therapeutic Milieu Approaches within a High Security Hospital: A Qualitative Analysis of Patients' Experiences of Ward-Talking-Groups

Running head title: Milieu Approaches in High Security Care

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4.1. Abstract

Objective: Research has shown that staff-patient relationships within secure forensic services appear to be influenced by an ethos of institutional control, most evident in the tensions of developing meaningful therapeutic relationships while continuing to maintain high levels of security. In an attempt to address the perceived deficits in these relationships, the development of a positive therapeutic milieu was proposed within a high security hospital. Ward-Talking-Groups (WTGs) were introduced as a first step towards the development of this milieu. The current study aimed to evaluate patients' experiences of being part of their WTGs. **Methods:** Semi-structured interviews were conducted with ten male participants detained with a high security hospital. The data was transcribed and analysed using Interpretative Phenomenological Analysis. **Results:** Three themes emerged from the data: *Coming together as a unit; Liberty Vs. Control, and Facing something new.* **Discussion:** The findings highlight the importance of patients being able relate to other people within their WTG, with the challenges and benefits of this being at the forefront of participants' minds. Participants described an increased sense of liberty with their WTG, while being acutely aware this was within the context of a high security hospital. Participants' feelings towards the introduction of their WTG appeared to be split; some felt ambivalence towards them, while others were open-minded about them. Reflecting on the introduction of their WTGs, participants shared the view that more information about them was necessary. However, they differed in their approach to seeking this out. Findings are discussed within the context of relevant literature and limitations of the study. Implications and future research are considered.

Keywords: therapeutic milieu, forensic, high secure setting, patient experience, intervention

4.2. Introduction

Patients detained within secure forensic services view the quality of the therapeutic relationship with "immense importance" (Coffey, 2006, p79). Regrettably, dissatisfaction within these settings is often associated with perceived deficits in these relationships (Ford, Sweeney, & Farrington, 1999; Byrt & Reece, 1999; Ryan, Moore, Taylor, Wilkinson, Lingiah, & Christmas, 2002). These relationships appear to be influenced by an ethos of institutional control, most evident in the tensions of developing meaningful therapeutic relationships while continuing to maintain high levels of security (Hinsby & Baker, 2004; Wilkinson, 2008).

In an attempt to address the balance between overt security and therapeutic practice, a high security forensic hospital proposed the development of a positive therapeutic milieu. It anticipated this would be achieved through the construction of positive learning and enabling environments that support personal development and skills acquisition, recovery and encourage self management' (TSH, 2009) (*See Appendix F for Clinical Model Principles*). In order to move towards the development of a positive therapeutic environment, therapeutic components were identified from an evidence base of milieu interventions that have been found to be effective.

Perry (2012) proposed a milieu model that drew upon the evidence for milieu interventions but did not seek to replicate them. He conducted a literature search using 'milieu therapy' and 'therapeutic community' as key terms in an attempt to identify key therapeutic components of successful milieu interventions. The search was limited to meta analyses, systematic reviews and randomised control trials (RCTs). It focused on the aggregated, quantitative outcomes for re-offending and psychiatric symptom reduction in patients with mental illness, drug/alcohol problems and personality disorders. Of the studies identified

(Lees, Manning, & Rawlings 1999; Sacks, McKendrick, Sacks, & Cleland, 2010 & Lykke, Oestrich, Austin, & Hesse, 2010), he reported that milieu interventions shared six key components: using the community as a therapeutic tool; opportunities for social learning; an emphasis on reality testing; increased permissiveness; a focus on democracy, and psycho-education. It should be noted these searches were not optimal due to omission of key terms (e.g. therapeutic milieu) and the limits placed on them.

On further exploration of these studies, they predominately refer to democratic therapeutic communities (TCs) and concept-based TCs (Lees et al, 1999; Sacks et al, 2010). The democratic approach was developed by Maxwell Jones as a professional groupwork method for the treatment of psychiatric difficulties, primarily using social learning principles (Jones, 1952). Rapaport (1960) summarises the democratic TC as having 4 principle themes: 1) Permissiveness: clients are free to express their thoughts and emotions without fear of negative consequences (e.g. punishment); 2) Democratization: clients and staff have equal opportunities to participate in the organisation of the TC; 3) Communalism: face-to-face communication and open interaction to create a feeling of sharing and belonging, and 4) Reality confrontation: clients are persistently confronted with their own image (and the impact of that) as perceived by other clients and staff members. These all refer to the conditions that must be present in the social system in order for treatment and rehabilitation to occur.

The concept-based approach was modelled on Synanon, founded by Charles Dederich. It was developed as a self-help movement for the treatment of substance misuse, primarily using behavioural modification techniques (Yablonsky, 1965). The overarching approach within this model is community as method, that is the "purposive use of the peer community to facilitate social and psychological change in individuals" (De Leon, 1997, p5). Vandavelde, Broekaert, Yates, and Kooyman (2004) summarise the following principles of

concept-based TCs: 1) Community: living together in a group and showing responsible concern and belonging is the main agent for therapeutic change and social learning; 2) Hierarchy: daily activities take place in a structured setting, where clients 'act as if' they have no problems and where older clients serve as role models; 3) Confrontation: negative behaviours, which conflicts with the community concepts, values and philosophy are confronted with clients being encouraged to behave in more appropriate ways. During confrontation feelings can be freely and openly expressed, and 4) Self-help: the client is central to their own treatment process. Other group members can only act as facilitators.

It has been put forward that underlying the therapeutic community approach is the understanding that an individual's psychopathology manifests itself within interpersonal relationships, with this pattern of relating being recreated within the context of community life (Schimmel, 1997). However, further examination of the milieu literature presents some significant challenges. It is apparent there is no one agreed upon definition for milieu therapy (Eldred, 1983) with this, understandably, impinging on the scientific communities' ability to establish agreement on the crucial components of the construct (Maurin, 1985). Delaney (1997) surmises that the confusion surrounding milieu therapy is due to the fact it can be interpreted within the context of three twentieth century influences: analytic/interpersonal origins, the community-as-doctor roots, and the sociological interpretation of milieu dynamics. She suggests that current interpretations of milieu therapy can be viewed in two ways: 1) milieu therapy has evolved to include all three of these influences that together define milieu treatment; or 2) these influences have evolved to form three different versions of milieu treatment: milieu therapy, therapeutic community and therapeutic milieu.

Although considerable efforts were made in the 1970/80s to clarify the definition of milieu therapy, this predicament led authors to adopt a "pick and choose" approach when deciding how to define milieu treatment (Delaney, 1997, p23). With the definition of milieu

therapy being open to interpretation and the terms used to identify these interpretations also being used interchangeably, there is an inevitable lack of clarity around the underpinning influences of the concepts put forward by individual authors. It is beyond the scope of this article to review these influences in further detail; however, consideration of the impact they have had on the development of TCs, and the resulting outcome research, is essential when considering the efficacy of TCs and the comparison of these across studies.

The efficacy of TCs was explored by Lees et al. (1999) in the first systematic meta-analysis of its kind. The analysis included 29 studies, ranging from 1960 to 1998. Where there was a choice of outcome measures and control groups, emphasis was placed on conservative criteria, such as reconviction rates and non-treated controls. The results indicated a strong positive effect for TC treatment ($ES = -0.512$; $CI = -0.598$ to -0.426). When these studies were grouped with regards to types of community, concept-based TCs were found to be markedly more effective than democratic TCs ($ES = -0.04$; -0.86). However, caution is suggested when interpreting these findings as there was considerable heterogeneity across the studies included in their review. That is, all of the concept-based TC studies were published later than the democratic TC studies, suggesting the methodological rigour of these studies would be greater. The patient population could also be a contributing factor to their findings as concept-based TCs only address addictions. Finally, the differences found might be due to variations in the TC regime itself.

The popularity of hierarchical TCs has diminished over the years, evidenced by the closure of many units. However, concept-based TCs continue to be popular, particularly in America, both in terms of numbers of TCs, and in the amount of research generated, although much of it is of variable quality and generalisability (Lees et al., 1999). Smith, Gates, and Foxcroft (2006) conducted a systematic review of RCTs assessing the efficacy of TCs for the rehabilitation of drug users. They found little evidence to suggest TCs offered significant

benefits in comparison to other residential settings with regards to treatment completion, attrition, retention, abstinence or employment. There was some evidence to suggest that TCs might reduce re-incarceration rates when compared to prison alone; with TCs also reducing recidivism when compared to mental health treatment programmes. However, firm conclusions could not be drawn due to the methodological limitations of the studies included. There was considerable potential for bias due to high treatment refusals and attrition rates. Only a few studies reported follow-up results with these also being compromised by attrition. Finally, the quality of reporting for included studies was generally poor and did not meet the recommended standards outlined in the CONSORT statement (www.consort-statement.org).

A similar review conducted more recently evaluated TC efficacy with regards to abstinence and explored whether there were any predictive factors of abstinence (Malivert, Fatseas, Denis, Langlois, & Auricombe, 2012). All twelve studies included in the review reported that substance use decreased during TC treatment. However, during follow-up 21-100% of participants had used substances or met the criteria for relapse, with 20-33% of participants reportedly being involved in another addiction treatment. They found that treatment completion was most predictive of abstinence at follow-up. The authors concluded that TCs did not appear to offer significant benefits over other treatment modalities. However, the heterogeneity across studies made it difficult for the authors to compare them. The conclusions drawn from this review were also limited by the methodological limitations of the original studies. These being an absence of data with regards to treatment status during follow-up; TC retention not being specified at follow-up, and only three studies detailing participant involvement in new treatment in order to control for potential confounders. Finally, no data was provided for the substance of relapse, leaving the reviewers unable to determine whether participants relapsed to their previous substance of addiction or to

another substance. These limitations could explain the significant variability in relapse rates at follow-up, which questions the reliability of results.

Recognising the crossover between hierarchical TCs and concept-based TCs, Broekaert, Vanderplasschen, Temmerman, Ottenberg, and Kaplan (2000) suggested they have enough in common to be considered subdivisions of the same modality, despite being borne from diverse roots. Historically there have been five proposals of integration of these two types of TC. Two were by Maxwell Jones (1979, 1984), founder of the democratic model, with three other proposals being put forward by authors affiliated with the concept-based model (De Leon, 1983; Rubel, Baker, Bratten, Hartwig-Thomson, & Smirnoff, 1982; Sugarman, 1984). The case for integration stemmed from the fact that: 1) both TCs are essentially democratic or peer driven, although with strong constraints; 2) concept-based TCs were widening their client group and becoming more professionalised, and (3) they were both effectively addressing different stages of the same treatment process (i.e. concept-based TCs are designed for early containment and behavioural change, with democratic TCs being designed for later intrapsychic change (Lees et al., 1999).

In the early 1990s the concept-based model was adapted with the aim of addressing co-occurring mental health and substance use disorders, diagnoses historically treated by separate services (Lykke et al., 2010). The prevalence of this co-morbidity being high among adolescents, the homeless, offenders and those with HIV/AIDS, created increased awareness of the cost of this problem and the need for treatment models that could address it (Sacks, Sacks, & DeLeon, 1999). Within the Modified Therapeutic Community (MTC), three adaptations were made in order to accommodate mental health problems: increased flexibility, reduced intensity/expectations and more individualization. However, the core principles of the TC, previously discussed, remained the same (Sack et al., 1999).

The efficacy of the MTC for clients with comorbid mental health and substance use disorders was supported by Sacks et al.'s (2010) meta-analysis. The studies included represented three different MTC settings and co-morbid populations (i.e. homeless persons, male offenders and outpatients). All studies compared the MTC treatment group with a treatment as usual control group. Outcome measures across all studies were substance use, mental health, criminality, HIV-risk behaviour, housing and employment. The results showed the MTC was associated with significantly greater improvement in 5 of the 6 outcome domains, all of which achieved a moderate effect size or similar: substance use (0.65), mental health (0.68), crime (0.66), employment (0.40) and housing (0.63).

However, the authors again highlight the limitations of their study due to the methodological limitations of original studies. One study, which compared two MCTs to one comparison group (De Leon, Sacks, Staines, & McKendrick, 2000), could have over or under estimated the effects of the MTC. Although they divided the sample size for the control group to ensure power was not overestimated, the use of control group means as comparison with both MCTs increased the potential for interdependency to occur. Studies also limited mental health outcomes to symptomatology and use of psychotropic medication. Due to the multidimensional nature of mental health, the inclusion of other outcomes was warranted. No consideration of the interactive relationship between various mental health measures, and mental health outcomes with those in other domains, was also considered to be a limitation. Finally, the way in which the MTCs were delivered and the meta-analytic techniques used limit the conclusions that can be drawn.

From the literature discussed, it is evident that the milieu research has been hampered by confusion around the definition of milieu therapy which has made it difficult to develop a body of research that supports it as an intervention with positive outcomes (Delaney, 1997). From the outcome evidence reviewed in this article, it is difficult to discern the efficacy of

concept-based TCs, modified or otherwise. Much of this appears to be due to the methodological limitations of the studies reviewed and the differences in TCs being assessed and the delivery of these. While further good quality research may shed light on this, currently the use of these TCs does not appear to be based on evidence of efficacy (Smith et al, 2008).

One consideration for the application of the components identified by Perry (2012), was the introduction of a community meeting within each ward of the hospital. However, there was concern around implementation of these given the potential for high levels of expressed emotion (EE) within these meetings. The concept of EE has traditionally been understood in relation to familial relationships, with it being well evidenced that levels of EE in family members are predictive of outcome across a range of psychiatric and physical health conditions (Wearden, Tarrier, Barrowclough, Zastowny, & Rahill, 2000). In people with a diagnosis of schizophrenia; there is strong evidence to suggest that exposure to high EE conditions significantly increases the likelihood of relapse (Butzlaff & Hooley, 1998).

An extension of the EE and schizophrenia research has explored relationships between patients and psychiatric staff. Although these relationships may differ due to less emotional investment from staff, both family and staff will frequently be exposed to challenging behaviours and spend considerable amounts of time with their mentally unwell relatives/patients (Kuipers & Moore, 1995). Berry, Barrowclough and Haddock's (2011) literature review found high EE ratings in staff-patient studies were almost exclusively based on the presence of critical comments from staff with very little evidence of hostility or emotional over involvement. This is particularly relevant in forensic settings where levels of EE have been found to be higher than other settings. Moore, Yates, Mallindine, Ryan, Jackson, Chinnon, Kuipers, and Hammond (2002) measured levels of EE in staff-patient relationships within three forensic inpatient units. Rating EE using the Five-Minute Speech

Sample, a screening tool for EE attitudes, they found that 73% of the their staff-patient pairs were high in EE. It was therefore considered prudent to develop a group that was tailored to this patient population in order to reduce the potential for high EE situations. These groups were described as ward-talking-groups (WTGs).

Another consideration when tailoring this intervention to this population, is the number of co-occurring complex needs patients within this setting generally have (e.g. attachment difficulties, substance misuse, cognitive impairment, psychosis, personality disorder) (Elsayed, Al-Zahrani & Rashad, 2010; Forensic Matrix, 2011; Adshead & Aiyegbusi, 2014). Engagement can be a particular problem for forensic patients (Glorney, Perkins, Adshead, McGauley, Murray, Noak, & Sichau, 2010). It should therefore be of the upmost importance that staff are aware that insecure patients may be dismissive or demanding due to their attachment disturbance, in order that they do not react in ways that might reinforce these attachment styles (Adshead & Aiyegbusi, 2014).

Although there is now a theoretical and practical framework in place for the implementation of these groups, as yet we do not know whether they contribute towards therapeutic change, as they have never been evaluated. Previous research in this area has largely focused on staffs' role in developing a therapeutic environment, rather than patients' perceptions of it (Thomas, Shattell, & Martin, 2002). Given that research has shown there are significant differences between patient and staffs' perceptions of ward environments (Rossberg & Friis, 2004; Archer & Amuso, 1980; Caplan, 1993; Miller & Lee, 1980; Skodol, Plutchik, & Karasu, 1980), it would be incorrect to assume the perceptions of staff reflect that of inpatients. It was therefore considered prudent to directly explore patients' perceptions of their WTGs. These findings well help to develop an understanding of the aspects of these groups patients find beneficial, with this potentially having implications for the existing theoretical and practical framework for these groups.

Although this could be evaluated using objective measures, it would not tell us anything about the meaning patients place on these groups or whether they themselves perceive therapeutic change within these groups. Historically, people with mental health problems have been viewed as being unable to adequately judge treatment due to their 'impaired mental status' (LeBow, 1982, p254). However, mental illness does not prevent people from offering lucid, valid and objective perspectives on the services they receive (Hoge, Lidz, Eisenberg, Monahan, Bennett, Gardner, Mulvey, & Roth, 1998). Additionally, mentally disordered offenders have the dual issue of being subject to criminal proceedings. The adverse effect of this, as well as the stigma associated with mental health problems serves to further reduce MDOs ability to fully participate in their treatment (Kelly, 2005). Therefore, in order to know whether WTGs contribute towards therapeutic change, it is of the utmost importance we gain insight into this populations personal experience.

4.2.1. Aim

The aim of this study was to evaluate patients' experiences of being part of their WTGs. The objective was to allow the voice of these patients to be heard by discussing their perspectives, opinions, thoughts and feelings about their subjective world. The findings of this study will help to develop an understanding of patient experience of the these groups in order to assist in service development.

4.3. Methodology

4.3.1. Interpretative Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) is a suitable qualitative methodological approach when one is trying to find out how individuals are perceiving a particular situation, and how they are making sense of their personal and social

world (Smith & Osborn, 2007). It was therefore considered to be the approach most able to address the aims of this study. IPA has been informed by three key philosophies: phenomenology, hermeneutics and idiography. It sets itself apart from other qualitative approaches as it offers the researcher the opportunity to engage with their research question at an idiographic (particular) level (Smith et al., 2009). The researcher enters into the participants' lived experience through a subjective and reflective process of interpretation. In contrast to some other qualitative approaches, they remain true to the data with regards to the inferences made. These are made cautiously with consideration of the contextual and cultural backdrop from which the data has been generated. However, interpretations that consider meaning, cognition, affect and action can be made, with these potentially being drawn from a range of theoretical perspectives, so long as these reflect the lived experience of the participant (their phenomenological world) (Reid, Flowers, & Larkin, 2005) (*See appendix G for the researchers reflections on conducting this research*).

4.3.2. Recruitment

Patients detained within the hospital are admitted via 3 routes: other hospitals within the NHS, the court system or prison. Around two-thirds of patients have a restriction order and/or previous convictions, generally of a violent and/or sexually violent nature. The majority of patients have a diagnosis of schizophrenia, with a small proportion attracting a diagnosis of intellectual disability (ID) (TSH, 2009). The hospital consists of 4 hubs each with three, twelve bedded wards attached. Patient care can be managed in all of these hubs, with one ward being reserved for patients with ID.

At the time of recruitment there were weekly WTGs running within 10 of these wards. Prior to the commencement of the WTGs, participants were given information about the purpose of these groups. This information was: to enable participants to hear more of

patients'/staffs' experiences than they normally would; to increase feelings of control about their immediate environment; to encourage participants to want to hear more about other peoples' experiences on the ward; to provide an opportunity to resolve issues between people who live or work on the ward; to help participants to understand people on the ward better. This was provided verbally and in poster form for mental illness wards. The same information was only provided verbally for patients on the ID ward due to cognitive limitations and a number of patients being illiterate. Staff also spent more time explaining the rationale in simple terms and reminding patients about their WTG. All patients were actively encouraged to ask questions about their group should they have any. However, there was and continues to be no check on consistency of information provision or the delivery of groups between wards.

One participant was selected at random from each ward and asked whether they would be interested in knowing more about the study. Random selection continued until 10 participants consented to take part in the study. In total, ten male participants were recruited to participate in the current study. All met the inclusion criteria. One of these participants acted as the pilot.

4.3.3. Inclusion and Exclusion Criteria

The inclusion criteria for this study were that participants were required to have attended their WTG on at least 2 occasions, in order to have sufficient experience of the group. It was also necessary for participants to have sufficient receptive and expressive language ability to allow them to engage in a semi-structured interview, even if additional support by the researcher would be required. This was determined by each participant's Responsible Medical Officer (RMO), who had extensive knowledge of these individuals. Finally,

participants had to be able to provide informed consent to participate in the study. All participants recruited for this study were able to provide informed consent.

With regards to exclusion criteria, a large proportion of the patient population within the hospital have active symptoms of psychosis. Therefore, this in itself did not exclude participants from this study. Participants were only excluded from the study if poor mental health was considered to hinder their ability to participate in an interview process. This was determined by their RMO at the recruitment stage.

4.3.4. Participant Characteristics

In order to retain anonymity, participant characteristics are presented for the group rather than individually. Ten participants were males aged between 31 and 56 years, and all were recruited from mainstream wards except for one participant who was recruited from the ID ward. The pilot participant was also recruited from the ID ward. The participants with ID had previously been assessed as functioning within the mild ID range. Due to no changes being made to the interview guide in light of the pilot interview, this was also included in the analysis. Time detained within TSH ranged from 3-15 years. A total of 10 interviews were conducted.

4.3.5. Materials

The semi-structured interview schedule for this study was developed following the guidelines by Smith et al. (2009). In line with IPA principles, interview questions were largely open-ended. However, due to the nature of the client population under investigation, a number of prompts were also included in order to encourage participants to expand their views. (*See Appendix H for Interview Schedule*)

4.3.6. Ethical Review

This study and all materials involved were subject to ethical review by both the University of Edinburgh and the high security hospital. This study was considered to be a service evaluation, therefore an Integrated Research Application System (IRAS) review was not required. IRAS is a system for applying for the permissions and approvals for health, social and community care research in the UK (*see Appendix I for documentation*).

4.3.7. Data Collection

4.3.7.1. Stage 1 (initial approach)

The principal investigator contacted the facilitators of the WTGs on each respective ward to identify potential participants. Facilitators from each ward were asked to provide the principal investigator with a list of all patients that had attended their WTG on at least two occasions. Once provided with these lists, the principal investigator used stratified sampling, whereby patients were grouped according to their respective WTG before one patient was selected at random from each stratum. A total number of 10 patients were selected. This ensured representation from a range of different WTGs within the final sample. The principal investigator then approached the Responsible Medical Officer (RMO) for each patient, to ascertain their eligibility to participate in the study (*see appendix J for RMO consent form*).

4.3.7.2. Stage 2 (providing further information/seeking consent)

Once written consent was granted by the RMO, the principal investigator asked the WTG facilitators to approach each patient to ask whether they would be willing to meet with the principal investigator to discuss participation in this study. Two patients at this stage refused to meet with the principal investigator. They were not asked why they made this decision and

they offered no reason. Therefore, the process described in Stage 1 was repeated until 10 patients in total agreed to meet with the principal investigator.

The principal investigator then approached all 10 patients to explain the aims of the research and ask whether they would be willing to take part. Each patient was also provided with a participant information sheet that described: (1) details about the aims of the study, (2) why they were asked to take part; (3) that participation was voluntary with the ability to opt out at any time; (4) what would be involved in participation; (5) possible benefits of participation; (6) possible disadvantages of participation; (7) that information collected was anonymous; (8) that information will only be used in the way described and (9) data will be stored for six years in line with NHS policy, at which point it will be destroyed. This sheet also included contact details should participants have any further questions about the study (*see Appendix K for Participant Information Sheet*). Any patient that preferred time to think about participation was approached within one week of the initial meeting. Three patients declined to take part in the study at this point. Therefore, Stage 1 and 2 were repeated with a total of 10 patients being recruited (*See figure 4.1 for depiction of recruitment process*). All participants were asked to sign a consent form prior to participation in this study (*see Appendix L for Participant Consent Form*).

4.3.7.3. Stage 3. Pilot Interview

At this stage one of the participants recruited from the ID ward were used as a pilot in order to identify any issues with the interview schedule. There were no changes made following this.

Stage 1

Attended WTG on at least 2 occasions
($n = 55$)



Total no. selected at random from each stratum ($n = 10$)



Stage 2

Eligibility confirmed by RMO
($n = 10$)



Initial approach
($n = 10$)



Refusals ($n = 2$)
Stage 1 repeated on these wards on one occasion each



Approached by Principal Investigator
($n = 10$)



Refusals ($n = 3$)
Stage 1 and 2 repeated on these wards on one occasion each



Provided informed consent ($n = 10$)

Figure 4.1: Flow diagram depicting the recruitment process

4.3.7.4. Stage 4 (interview)

The principal investigator arranged to meet with each participant, at a time convenient for them and ward staff, to conduct their interview. Prior to meeting with each participant, the principal investigator sought an update from ward staff with regards to the patient's current presentation. Had this been a cause for concern, the interview session would have been rescheduled. However, no participants gave any cause for concern prior to or during their scheduled interview session. In line with hospital policy, the principal investigator also had a personal attack alarm on her person at all times.

Each participant was interviewed individually in a quiet room. The principal investigator conducted the interview and was also available to answer questions participants had before or after the interview. Interviews ranged from 25 minutes to 1 hour 15 minutes. On average interviews lasted approximately 40 minutes. One participant's interview was removed from the analysis (Participant J) as their responses were monosyllabic (e.g. "no" and "sometimes"), this provided no scope for analysis and resulted in an interview length of less than 15 minutes. The interview was recorded to allow the interviews to be transcribed. Given the likelihood that participants in this setting would not actively seek out feedback about the findings of the study, the principal investigator proactively offered to arrange to meet each participant to offer feedback about the findings of the study. However, participants were free to opt out of this meeting at any time.

4.3.8. Analysis

Data was analysed according to the guidelines suggested by Smith et al. (2009). Transcripts were read and re-read before being transferred on to a table with 3 columns. This allowed initial comments to be noted in one column and emerging themes in the other. Areas that appeared emotive for the participant, were mentioned frequently and/or interesting on

consideration of the individual's overall narrative were noted. The researcher's reflections were also noted in this column, starting the interpretation stage. Using these notes, emerging themes were noted in the third column, considerable effort being made to ensure these were clearly linked with the relevant interview extracts. (*see Appendix M for a sample of the analysis*).

The interpretive process was continued as the researcher looked across themes to create higher-order themes. Themes and sub-themes were transferred into a table and illustrated with quotations. Once this was completed for one participant the researcher moved onto the next participant. In order to analyse each transcript in their own right, ideas from the first participant were bracketed where possible, while the same process was followed for the second transcript. When all nine transcripts had been coded, the researcher searched for recurrent themes across participant accounts. These themes were analysed until such point as they appeared to capture the whole data set. These findings were then further interpreted within the context of the researcher's current knowledge and relevant literature (*See N for recurrence of themes*).

4.3.9. Quality assurance

It is important to acknowledge the inevitable subjectivity within qualitative research. It is therefore essential to refer to recognised guidelines to assess the quality of qualitative approaches. Yardley (2000) proposes broad principles that are characteristic of good quality qualitative research: *sensitivity to context; commitment and rigour, transparency and coherence, and impact and importance*. There are a number of forms these principles can take, some of which were employed in this study.

An appreciation of the interactional nature of data collection within the interview situation, particularly with regards to detained MDOs was demonstrated. There was an

awareness that patients were primed to report positive experiences if they perceived participation to be associated with progress through the system. To ensure participants were fully aware their participation had no bearing on their care and treatment, continued emphasis on this was given by the researcher at recruitment and interview stage. It also featured on the participant information sheet. Given the highly controlled nature of the environment, attempts were made to put participants at ease by providing flexibility around their interview time. Sensitivity to the raw material was also provided by verbatim extracts from participants transcripts being used to support the analytic claims being made. This gave participants a voice within the study while allowing readers to further assess the interpretations made by the researcher. It also provided an opportunity to ensure interpretations made sense to others (Yardley, 2000, 2008). Rigour was also demonstrated by documenting the prevalence of themes across participants. Smith (2011) suggests a sample over eight should provide extracts from at least three participants for each theme with an indication of prevalence of themes across the sample (*See Appendix N for depiction of theme recurrence*).

Triangulation of data was also used to ensure the researchers understanding of the current phenomenon was not based solely on her own perspective (Yardley, 2000, 2008). Samples of transcripts were discussed with supervisors throughout the interpretative process, allowing them to share their own experience and insights with regards to emerging themes. This enhanced the richness of the researcher's understanding of the phenomenon under study while also increasing overall transparency of her analysis.

It is also important to acknowledge the values, interests and assumptions of the researcher and how these may influence the understanding of the phenomenon under study (Elliot, Fischer, & Rennie, 1999). Therefore the researcher practiced reflexivity when considering her role in the study to ensure her perspectives were transparent from the outset. The researcher was a novice qualitative researcher and had attended a number of WTGs prior

to undertaking this study. She had also worked with detained MDOs in varying capacities for several years. In this time she has gained the impression that clients within these settings can often view their participation in psychosocial interventions as an opportunity to improve their chances of liberty, rather than to improve their psychosocial functioning. Literature was also reviewed prior to the study that highlighted an ambivalence around the efficacy of milieu interventions.

Reflective practice revealed the researcher's belief that patients with in this setting often feel they have no choice when engaging in psychosocial interventions, which would inevitably impact on their perception of them. This prompted interest in the study as WTGs are considered voluntary. Attending the WTGs had also given the researcher insight into how these groups are experienced from a staff members perspective, peaking her interest about how these compare to patients perceptions of these groups.

4.4. Findings

The central phenomenon was patients' lived experience of their WTGs. Three super-ordinate themes emerged from the data. These were: *Coming together as a unit; Liberty Vs. Control, and Facing something new*. These themes and the sub-themes contained within them are depicted in figure 4.1.

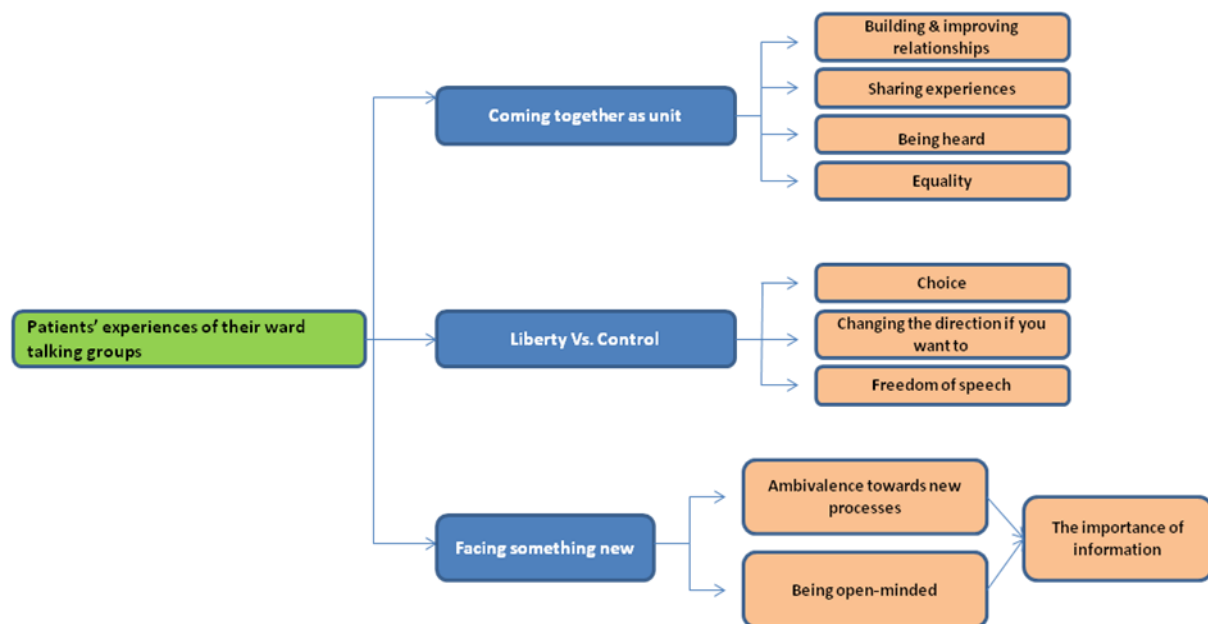


Figure 4.2: Schematic representation of superordinate and subordinate themes

4.4.1. Coming together as a unit

This theme was relevant for 8 of the 9 participants and described patients' understanding of what it meant for them to be in relation to other people within their group. The benefits of this, as well as the challenges, were apparent from participants' narratives. The four subordinate themes contained within this theme were: *Building and improving relationships*; *Sharing experiences*, *Being heard*, and *Equality* (Depicted in figure 4.2).

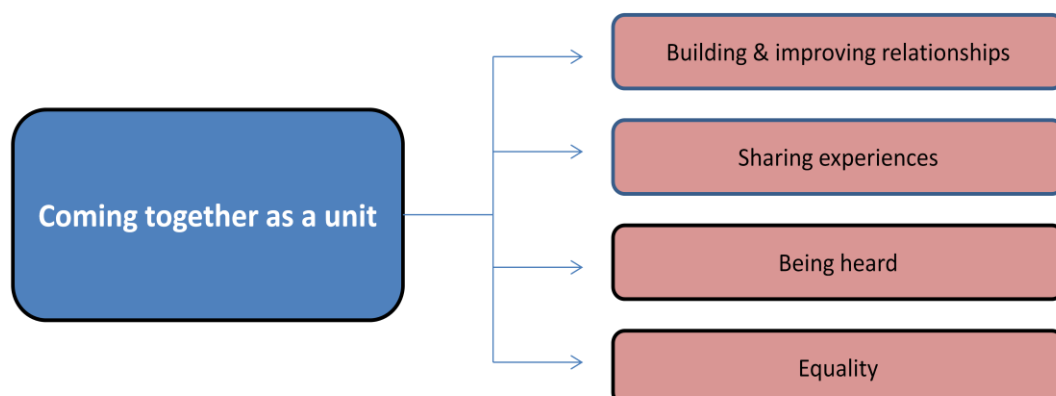


Figure 4.3: Subordinate themes linked to 'Coming together as a unit'

4.4.1.1. Building and improving relationships

The participants described their WTG as an opportunity to build new relationships and improve on existing ones. The establishment of these TGs was viewed as a chance to relate to other people, something they appear to have done to a limited degree previously. Participants reported an improvement in their relationships as a result of this:

A: It's a good opportunity for everyone to be together as a unit, instead of it being individual people, patients and the staff. I: Can you tell me more about that? A: Well you get on a lot better... (Participant A)

It's nice to talk to other people, who I didn't talk to before, it's a good thing....there is a few patients who I get along with now. (Participant E)

There was a sense participants did not fully know peers and staff prior to their WTG. They described seeing a side to staff and peers within the group they did not normally see:

Some of the boys (peers) have actually surprised me, spoke about things that I didn't think they would speak about, getting to know people a bit better and seeing a different side of them. It gives you a bigger picture, it's a positive. I know more people better. (Participant A)

Some of them you see their intelligent side, some of them have good stuff to say. You don't see that when they are doing their nursing. It should happen more often. (Participant B)

In some cases, this might be partially due to their own perception of those around them. However, this might also be related to how people choose to present themselves to others and/or boundaries being in place that prevent people from fully being themselves. The group appeared to allow participants to be more open with one another and offer group members the opportunity to explore their perceptions of other people. This facet was viewed positively and was reported to have resulted in an improvement in relations among staff and peers by some participants.

4.4.1.2. Sharing experiences

Participants predominately viewed their WTG as a place to share with others. However, the way in which sharing was viewed differed significantly between patients. While several found it to be a beneficial experience, others found it difficult:

You can...bring up a subject that you want or something you want to get off your chest, you use the talking group to do that. (Participant D)

E: The worst thing was having to talk about your feelings and everything. That's difficult to talk about. I: What were you thinking or feeling in that situation? E: I just wanted to get up and walk out, I did, I just got up and walked out. (Participant E)

Differing opinions appeared to be based on participants' perceptions of their role within the group. Although the group is voluntary, the language used by participant E ("having to") suggests he felt he had to talk about his feelings or leave the group. However, participant D appeared to view sharing within the group as voluntary ("you want") and an opportunity to share problems with the potential for support.

4.4.1.3. Being heard

Participants associated the group with being heard by others and hearing what others had to say. This appeared to be important for some participants, with it being their initial motivation for attending the group:

I just decided that I had things to say.. I knew I was going to get more opportunity to talk and hear what other people's angles were... I remember thinking I wanted to know what my pal had to say, he wanted to raise a few things. (Participant A)

Speaking about everyday topics, whilst normal in the community, had to be considered by this patient with a decision being made to speak and listen to other people. The advent of the group appears to have made this participant aware of his own voice and peaked his interest for what others had to say.

Being heard seemed like a novel experience for some participants, particularly with regards to staff listening to them within the group. The use of language by participants suggests they do not feel what they have to say is necessarily important enough to be heard:

...there are members of staff that will sit down and have a laugh and they will be willing to listen to the nonsense that we talk. (Participant A)

A wee bit different, they were just understandable (context suggests participant meant understanding) and they were listening, I felt that I was being listened to. (Participant E)

There was a sense of appreciation that staff not only took the time out to listen to them but were paying attention to what they had to say.

4.4.1.4. Equality

Equality also emerged as a sub-theme for some participants. For Participant G, staff held a dual role with regards to equality. While he felt it was “*important for them to have their say*”, he was also comforted by the idea staff would maintain equality among peers:

Once I was there and (staff member), (staff member) and (staff member) came down, when they were ready, I felt a wee bit at ease as they were interacting and talking about people respecting each other's points of views, which made a difference. (Participant G)

This suggests the participant might have had some concern about how interactions would have played out had staff not been there. It seems staff presence, for this participant, might act as a protective factor in establishing equality in communication among peers.

More generally, staff participation appeared to be at the forefront of some participants' minds:

Well, the staff always join in as well as the patients. Its fine, there are no problems at all, it's nice for them to join in. (Participant D)

Even the staff come in and have a chat with us and that. (Participant H)

There was the sense while staff involvement was appreciated; it was not something that was necessarily expected by participants. Phrases such as “*it’s nice for them to join in*” and “*even the staff*” suggest these participants view staff participation as a nice gesture, rather than a meaningful activity for staff as well as patients.

However, the importance of everyone being able to express themselves within the group was highlighted by participants:

I think having staff and patients together in the talking group is a positive thing. They can get their point of view across and the patients can do the same. (Participant D)

I like it because talking (referring to the WTG) just gives everyone a chance. If you want to talk about something then you need to wait, its more relaxed. (Participant H)

Participant H’s use of the word “chance” suggests he might feel dominated by other patients in social situations out with the group. Within the group all members appear to be given the opportunity to speak.

4.4.2. Liberty Vs. Control

This theme was relevant for all participants and described patients' perception of liberty within the group but also the influence being in a high security hospital had on this. The three subordinate themes contained within this theme were: *Choice*, *Changing the direction if you want*, and *Freedom of speech*. (Depicted in figure 4.3).

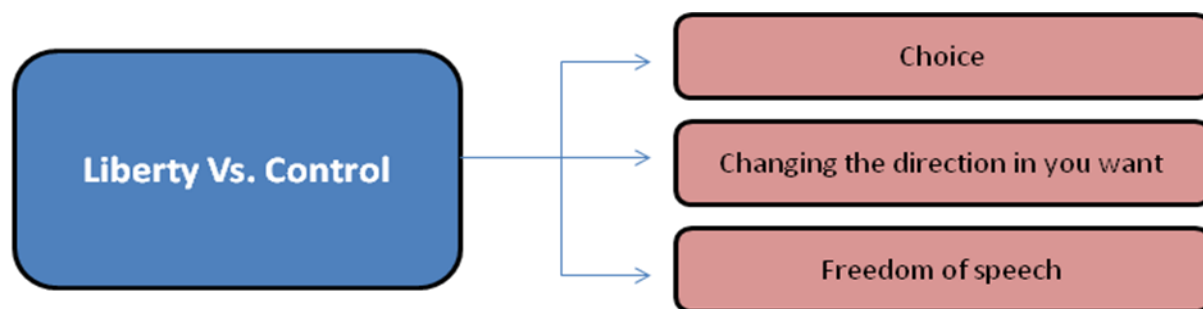


Figure 4.4: Subordinate themes linked to 'Liberty Vs. Control'

4.4.2.1. Choice

The general consensus amongst participants was their WTG was voluntary. However, their definition of choice appeared to be within the context of their detention within TSH. Their choices appeared to be restricted by their beliefs around the perceptions of others, peer influences and the lack of a better alternative. For instance:

It was in that room and that's where I was anyway so I just joined in but I wanted to anyway. My seat is there in the corner and the group gets held in that room. I would have had to get up and go away somewhere else. That would have seemed a bit ignorant. But I did want to go anyway. (Participant D)

...one day after the group I saw the staff going over to the computer and I wondered what they were up to and they said that they have to go on and log that you were at the group, they never told us about that, we weren't told that it gets noted. This tells me that there is more to it, a hidden agenda, similar to the groups that you go to. (Participant B)

Participant D's comments suggest his decision to attend his group might have been influenced by how it would be perceived by others if he had not. He believed removing himself from the group would have been viewed as "ignorant", therefore he chose to stay. Although he states

he "did want to go anyway", due consideration needs to be given as to how he perceives his choices are being viewed within the confines of TSH. This feeling of continual assessment is also apparent in Participant B's comment.

There is also a sense that acceptance of the group by other peers might influence participants' choice to attend. Participant B's comment highlights the importance of not being mocked for attending the group; while participant G's decision appeared to be made easier by observing other peers attending the group:

It seems to go alright, everyone can see what is going on, if they want to come in they can come in, you don't have to, no one takes the piss out you for going, no one sniggers or laughs, it just happens, the group happens. (Participant B)

Eh.....there were quite a few people interested in it and I was quite surprised to see a few people there who I didn't think would go so that helped ease it a bit. (Participant G)

Finally, for one participant, attending the group was not necessarily perceived to be a choice as he believed there was no better option:

Well, it was better than sitting about not talking, it's better than sitting about watching tv and it's good to have a forum where you can talk about things.

(Participant G)

4.4.2.2. *Changing the direction if you want*

This subtheme described aspects of the group that made it feel like an "everyday" experience. This appeared to be due to the unstructured nature of the groups, with the resulting versatility this afforded. Participants felt this was possible due to the WTGs negotiable boundaries. The unstructured content of WTGs was viewed favourably, with several participants reflecting on the benefits of this:

Aye, there is no homework, there is no role plays, there is no formal learning, you don't need to learn things, you just go and talk about whatever. (Participant B)

As I say, talking group is relaxed and it is just everyday things that you can talk about anything. Coping with Mental Illness is nothing like that. (Participant I)

When discussing the informal nature of their groups, there was a sense participants felt the WTGs had stripped away the structured components of group interventions. Participant B lists the tasks he finds "formal" in other groups, while Participant I's use of language ("just") emphasises the basic nature of his WTG.

The limited structure within the WTGs appeared to go hand in hand with a sense of versatility. This allowed the group to flow more naturally for participants, rather than being restricted to particular topics:

The topics we talked about, we talk about some interesting things. Sports, Music, Movies, TV, food. A huge variety, it keeps it interesting. (Participant C)

I suppose, the subjects just go from one to another and the direction changes, depending on what you say.... some people just chat, some people tell jokes, people have the opportunity to say what they want to say. (Participant D)

The way in which participants list the topics available for discussion, highlights the sense of options they feel within their WTG.

The negotiable boundaries inherent within the group appeared to be the most salient reason for viewing the group as unstructured. This predominately referred to the physical boundaries of the group:

I had about 20 minutes before I went to my placement at Arts and Crafts so I thought I would go in for 20 minutes and I was surprised and when Arts and Crafts did phone for me, I thought about staying, it wasn't a big deal leaving the group while it was on. In the past, at the monthly meeting in the old hospital, you would normally have to wait until you were finished the meeting before you could go. (Participant A)

I was quite happy with that because it meant that I could go out and go to my placement if I wanted. I don't need to go in because I have the cooking group on a Thursday afternoon as well. I spoke to (staff member) about this and it wasn't a problem. (Participant E)

However, the positive aspects of negotiable boundaries were not always about the removal of these. Rather, being able to reinstate boundaries, when perceived to be necessary, was also viewed positively by two participants:

When we were in the day room it was the guy's body language that I didn't like. It made it less comfortable for me because I could see other people saying I don't want to be here and I thought – there is no need to be like that. It made me feel uncomfortable. It was (staff member's) idea that we go into the dining room and it was a great idea. (Participant A)

We put bits of paper up so that we would not be disturbed. (Participant H)

The use of words like "idea" and "we" suggests negotiation took place prior to these boundaries being established. These appeared to be for the benefit of the participant, rather than being imposed upon them. However, boundaries being established without patient knowledge and/or agreement was not welcomed by one participant:

There is usually a sign put up saying "this is the talking group". Which I don't know why because you can clearly see through the glass. I think it might make it too formal for some. (Participant B)

Participant B appears to be confused by this boundary as, for him, it serves little purpose. He thinks this boundary might deter people from attending the group as it is "too formal".

4.4.2.3. Freedom of speech

Another theme relevant for all participants was the issue of freedom of speech within the group. Participants appeared to be describing the freedom to explore the continuum of social interaction they perceive to be unavailable to them in more structured group settings:

It was just a group that you could be free to talk about what you want, it was like a discussion group. (Participant I)

In the talking group you can talk about the world in general, you can talk about anything. (Participant E)

Within forensic mental health settings, structured group interventions are the main stay of therapeutic interventions. Most patients have taken part in these types of interventions during their time at TSH. This emphasis on structure appears to be central in some participants' minds when considering the informal communication with their WTG. Engaging in an open manner is not something that appears to come naturally for some participants. Participant C expresses his initial reluctance due to concerns there would be repercussions for speaking freely:

We spoke about it out on the grounds and with staff and that. We thought if we spoke about something outside on the grounds that we might get into trouble for that, we weren't sure. (Participant C)

This difficulty in stepping away from the structures imposed within interventions is further emphasised by Participant B's comment:

I identified quite early on what I was doing, I just thought 'I'm doing this here' and then I would be talking about something semi-serious and someone else would talk about their Auntie who went to the shops that day or something and then I realised that at the

Talking Groups, you can talk about anything, you don't need to talk about serious things or issues. (Participant B)

Participant B describes a process of realising he was using the WTGs as a psychological therapy session. There was a sense that previously communicating in a structured way had limited his ability to speak more freely about what was on his mind. It was only through listening to other people he realised he did not have to approach the TGs from a "serious" stand point.

The importance of engaging in the less serious aspects of social interaction is also apparent in Participant A and G's comments:

...no matter how trivial, you can talk about what you want. (Participant A)

The main difference is that the Talking Group is light hearted, where CBT, SVRR, are working groups but it's not as relaxed and free flowing, I'm trying to say that there is no set structure, you can discuss anything. (Participant G)

The freedom to express feelings was also evident within participants comments. The importance of being able to share feelings that were not necessarily positive was highlighted by Participant A and D. Reflecting on the acceptance of negative feelings in the group (e.g. *"that's fair enough"* and *"It's all positive"*) suggests these types of feelings might not be shared and/or accepted in other settings:

It was like one day I was annoyed and I had a wee grunt and that's fair enough.

(Participant A)

I don't know, people say what they feel they need to get out or they use it to complain about something. It's all positive. (Participant D)

The group also appeared to be an opportunity to challenge the interpersonal status quo for some participants:

...you can get a wee ding-dong going with them (staff) if you disagree on what they are saying or you might think you have a better opinion. You get to see a bit about them, which helps you if you know more about them. (Participant B)

Participant B describes a purposeful disagreement with staff in order to learn more about who they are. Due to the inevitable power imbalance within the hospital, it is likely disagreeing with staff is not something patients routinely engage in. However, within the group he felt able to push these interpersonal boundaries.

4.4.3. Facing something new

This theme was relevant for 8 of the 9 participants and captured the challenge of facing something new in participants' day to day lives and the ways in which they chose to approach this. Three super-ordinate themes emerged from the data. These were: *Ambivalence towards new processes*, *Being open-minded* and *The importance of information*. The latter was intrinsically linked to the prior two themes, as depicted in Figure 4.4.

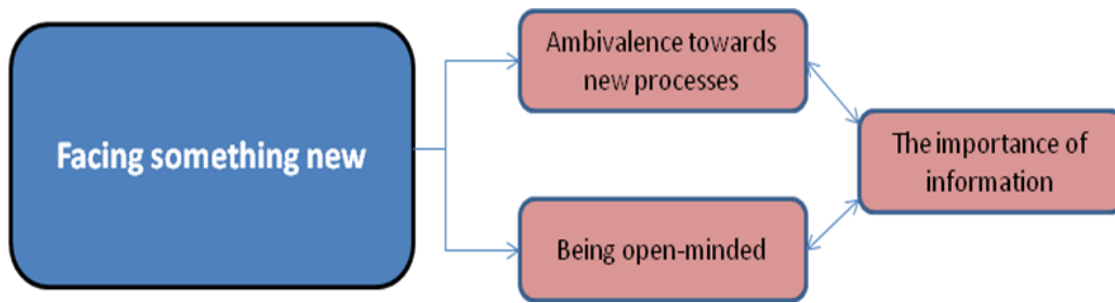


Figure 4.5: Subordinate themes linked to 'Facing something new'

4.4.3.1. Open-minded versus Ambivalence

When considering attending their WTG, participants appeared to be split with regards to their thought processes around this. Some participants appeared open to the idea of 'testing out the group'; while others appeared to be initially ambivalent towards attending their group:

I thought I would just go and see what it was about.. (Participant H)

I wasn't sure if I wanted to go and sit down and listen to people's moans...

(Participant A)

There appears to be varying reasons for this ambivalence among participants. For some this centered around being unsure of new processes and their attitude towards this, other participants voiced suspicion around changing processes:

People in general don't like talking and they maybe don't know what is going to get spoken about. They maybe think that they are going to get made to talk about their selves, they don't know. (Participant B)

Participant B shared that he didn't believe people liked to talk as though he knew this to be a fact. This is likely to be transference of his feelings on to others. It seems his discomfort with regards to talking is the unstructured nature of the group.

Participant A thought some participant's ambivalence might be due to negative authoritarian attitudes:

Well, unfortunately a lot of guys have given up, a lot of them, as soon as they go into an institution it becomes a "them and us" situation. Some people have a chip on their shoulder, I don't think it's anything to do with the group, and it's just to do with the authority.
(Participant A)

Participant A taps into a common problem within forensic settings. As people within these settings are detained against their will, a power imbalance within staff and peer relations is inevitable from the outset. He seems to be alluding to the fact that anything within this setting is tainted by these perceived relationships before being given a chance. He goes on to provide an example of being confronted by these negative attitudes:

I've had guys ask me what do you go in there for, it's just nonsense and I would say, how do you know if you don't go. You can't say, I think cycling is not fun when you can go and have a good laugh. I just say to them come and join in, you don't have to stay for long, give it 20 minutes and see what you think, if you don't want to stay, just have a cup of tea and then go. You don't need to be rude, you won't insult anyone, and no one will take it to heart.
(Participant A)

In this situation Participant A chose to be an advocate for the group. When defending the group he highlights its flexible boundaries as a selling point, assuring patients leaving early would not be a problem. This suggests he too is aware of and is likely to have been subject to a more structured routine in the past; however, this has not stopped him from attending the group.

Suspicion also arose as a reason for ambivalence towards attending the talking group. This appeared to be in relation to processes changing in an ad hoc fashion (i.e. brief notes being taken).:

You don't know what is getting noted though, they might be noting about mood and attitude and then it gets discussed at the Thursday meeting. What they sold it as is now different. It was sold as an informal talking group and without being told, I had to ask, they are taking notes. (Participant B)

There is nothing negative about it but I'll tell you something, when we started it, I said to (staff member), would you be doing reports on us and she said no, but then a few months later she said we might write about some stuff and we might not...(Participant H)

It seems concern about progress within the hospital might be the root of this suspicion. If these participants believe there is a risk these notes might reflect on them badly, they are less likely to engage.

4.4.3.2. *The importance of information*

Despite participants being split with regards to their thoughts about attending the group, they appeared to share the expectation of receiving more information about their WTG. While more open-minded participants were willing to explore this by participating in the group, more ambivalent participants were keen to learn more about the groups prior to their attendance and/or participation:

(Discussing his decision to attend) *Because I seen it was harmless after a while, I didn't know (staff member) in the beginning.* (Participant B)

...when the groups first started four or five of them wouldn't say a word, they used to just sit their but now they are bringing things up. (Participant H)

Learning about the group vicariously appeared to be important for more ambivalent patients. For participant B, observing the group from afar allowed him to learn the group was "harmless" without putting himself at risk. Whereas participant H felt his peers were present but not participating initially. It seems his understanding is these peers were wary about participation until they had the opportunity to gather information about the group.

4.5. Discussion

4.5.1. Summary of Main Findings

This study sought to evaluate patients' experiences of being part of their WTG. This was achieved by interviewing ten participants who had experience of participating in their WTG, with analysis of their transcripts using IPA. The current findings suggest *Coming together as*

a unit; Liberty Vs. Control, and *Facing something new* were important themes for these participants.

The findings highlight the importance of patients being able relate to other people within their WTG, with the challenges and benefits of this being at the forefront of participants' minds. Participants described increased sense of liberty with their WTG, while being acutely aware this was within the context of a high security hospital. Participants' feelings towards the introduction of their WTG appeared to be split, in that some felt ambivalent towards them, while others were open-minded about them. Reflecting on the introduction of their WTGs, participants shared the view that more information about them was necessary. However, they differed in their approach to seeking this out. Some participants attended their WTG to find out more, while others chose to vicariously learn about their group through peers prior to attending and/or taking part.

4.5.2. Consideration of Main Findings within the Context of Relevant Literature

The WTGs were developed within the context of a milieu model informed by the evidence base for TCs. However, the aim was not to develop a TC but to introduce the therapeutic components of TCs within a group environment (Perry, 2012). Therefore the WTGs are a novel intervention. As a result, the findings of this study are not directly comparable to the milieu evidence base. Furthermore, previous research in this area has largely focused on staffs' role in developing a therapeutic environment, rather than patients' perceptions of it (Thomas et al, 2002). Therefore, when discussing patients' perceptions of their WTGs, it was necessary to place the current findings within the context of patients' experiences of secure forensic services more generally.

4.5.2.1. *Coming together as a unit*

For the majority of participants the WTG offered an opportunity to relate to other people. Prior to the WTGs, interactions appeared to be limited; leaving participants with a sense of not really knowing peers or staff. Attendance at their WTG was viewed as a chance to get to know people better. Within their WTG participants believed they saw a different side to staff and peers. This is highlighted by one participant's description of his experience of staff during the group (*"you see their intelligent side, some of them have good stuff to say"*); in contrast to his experience of staff in the wider hospital environment (*"you don't see that when they're doing their nursing"*). Viewing this other "side" to staff and peers was a unanimously positive experience for participants and suggests the side perceived prior to the group might have been less so.

Previous literature exploring patients' experiences of secure forensic settings highlights the importance patients place on their relationships with staff. Bressington, Stewart, Beer, & McInnes (2011) demonstrated that patients perceptions about therapeutic relationships with staff were associated with satisfaction with inpatient forensic treatment. Unfortunately perceived deficits in these relationships is a common theme within these settings; with previous research indicating that patients view staff as being preoccupied with maintaining custody and control, to the detriment of therapy (Hinsby & Baker, 2004; Meehan, McIntosh, & Bergen, 2006). It might therefore be reasonable to suggest that participants dual experience of staff might allude to these role tensions.

Conversely, patients also felt their WTG allowed them to get to know peers better too; suggesting limited experiences of relating to others might also be attributable to characteristics of forensic inpatients. Experiencing others in a limited way is consistent with a fearful attachment style, whereby other people are kept at a distance as a means to protect the individual from being hurt (Baron & Byrne, 2004). Timmerman and Emmelkamp (2006)

found criminal status was significantly linked to a fearful attachment style; with this being characterised by avoidance of close relationships due to fear of rejection, personal insecurity and a distrust in others. These findings are consistent with previous research on the learning histories of prisoners and forensic inpatients (McCord, 1979). Furthermore, within a criminal environment, this style of relating is reinforced as distrust in others might be viewed as a means to 'survive' (Timmerman & Emmelkamp, 2006, p.53).

More recently a measure of ward climate had been developed specifically for forensic populations (EssenCES, Schalast, Redies, Collins, Stacey, & Howells 2008). The Essen Climate Evaluation Schema measures ward climate along three dimensions: therapeutic hold (TH), patient cohesion and mutual support (PC) and experienced safety (ES). Research using this tool has found that higher levels of security is associated with poorer perceptions of ward climate (Long, Anagnostakis, Fox, Silaule, Somers, West, & Webster, 2011). More specifically, Dickens, Suesse, Snyman, and Picchioni (2014) found higher levels of perceived risk were associated with lower levels of patient cohesion and mutual support. While this literature demonstrates the institutional and personal characteristics viewed as obstacles when developing relationships within secure forensic services; current findings suggest the WTGs might provide a space where some of these challenges can be addressed.

The majority of participants viewed their WTG as a place to share experiences, with this generally being valued. Previous qualitative explorations of group work experiences within secure forensic services share common themes around the value of sharing experiences, irrespective of group focus (Daniels, Skinner, & Todd, 2014; Conway, 2010). Their themes are comparable to the current findings in that participants felt group work offered the opportunity to share problems with the aim of feeling better. However, not all participants viewed sharing experiences favourably. Despite participation in the WTGs being explicitly voluntary, one participants use of language suggests he felt he had no choice but to

share his experiences or leave the group. This perception of coercion is consistent with previous research in secure settings. O'Donogue, Roche, Shannon, Lyne, Madigan, and Feeney (2014) found that even voluntary patients treated within a secure ward were more likely to report higher levels of perceived coercion during their admission, with this also being associated with more severe positive psychotic symptoms.

Although this experience was only reported by one participant, it does raise an interesting issue around whether voluntary activities are necessarily perceived as a choice within secure services. It is true that the majority of activities patients will engage in within these services will be imposed upon them due to an identified need within their care and treatment plan, with compliance with this being associated with progress through the system. It may therefore be important to explicitly explore patients' understanding of the voluntary nature of WTGs to ensure they do not feel they are being coerced into attending them.

Being heard, particularly by staff, appeared to be the initial motivation for some participants to attend their WTG. Participants appreciated not only staff spending time with them, but paying attention to what they had to say. The importance of being listened to by staff and the difficulties associated with this within inpatient and forensic inpatient services is highlighted by previous research (Meehan 2006; Mezey, Kavuma, Turton, Demetriou, & Wright, 2010; Forchuk & Reynolds, 2001). Long, Knight, Bradley, and Thomas' (2012) exploration of service users views on key elements of effective therapeutic milieus in secure services for women, revealed good interpersonal relationships as key, with the ability to listen and understand as an integral quality of staff. Another study found that a perceived failure of staff to listen to patients left them with the impression that staff did not care (Forchuk & Reynolds, 2001). It is therefore reassuring that WTGs appear to offer a dedicated time where staff are viewed as fully attending to patients.

Finally, having equal opportunities to communicate within the WTG was relevant for participants. While some spoke positively about staff and patients having the same opportunity to contribute to the group, staff attendance appeared to be viewed as a nice gesture rather than an activity staff would view as meaningful. This suggests some participants do not view staff as necessarily belonging to the group in the same way as patients. Some participants appeared to view the role of staff as agents in maintaining equality among peers, rather than being viewed as group members in their own right. Interestingly, it appeared to be the balance of power between peers that was most important for some participants, suggesting a power differential exists among patients. This finding is comparable to literature on social hierarchies within prison settings. For example, prison hierarchies appear to be organised by criminal status, with inmates who have committed crimes against children being at the bottom of the hierarchy (Crewe, 2007). Although these participants are currently detained within a hospital setting, a large majority of the patient population will have been transferred from prison.

These findings highlights the importance of being aware of the history of group members and how this might influence the dynamics of their WTG. The significance of the dual role of staff within secure settings is also brought to the fore by participants. While previous research has shown that patients can feel staffs' dual role of custodian and therapist is detrimental to relationships (Hinsby & Baker, 2004; Meehan, McIntosh, & Bergen, 2006); it appears some participants value staffs presence in a management role within the WTG. While staff being viewed as part of the system is inevitable within secure forensic services, this facet of staffs' role appears to be viewed favourably when its function is perceived as supportive.

4.5.2.2. *Liberty Vs. Control*

The experience of liberty within the WTG was salient for all participants. However, there was an awareness this perceived freedom was within the confines of a high security hospital. The consensus among participants was that attendance at their WTG was a choice but this appeared to be influenced by factors specific to their current detention. Some participants' decision to attend the group appeared to be influenced by other peers attendance/acceptance. Although this might be due to anxiety being reduced by strength in numbers, given the earlier suggestion of a social hierarchy among peers, there may also be pressure within the ward environment to conform.

For some participants there appeared to be some motivation to attend the group due to how it might be perceived if they chose not to. This sense of behaviour being judged also emerged for other participants. One participant described the groups as having "*a hidden agenda*" when he discovered his attendance was being documented by staff. He believed this documentation proved the WTGs had a similar agenda to other groups he attended (i.e. therapies). It is reasonable to assume this comment related to attendance/compliance being associated with reduction in risk (Webster, Douglas, Eaves, & Hart, 1997). This focus for these participants might capture the pressure experienced by patients within secure forensic services to behave in ways that are deemed low risk (Heyman, 2010). Some research has shown that patients within these settings will attempt to manage their own risk status by modifying behaviour they view as an indicator of risk (Reynolds, Jones, Davies, Freeth, & Heyman, 2014). This finding again demonstrates the difficulties associated with the concept of choice within a secure environment.

For the majority of participants the WTGs were a move away from the structured nature of other group settings, with participants viewing them as informal and relaxed. The removal of the structured components of a group appeared to offer patients a level of

versatility with regards to the content of the group. This was experienced as a more natural way to communicate, with topics of conversation flowing more easily. This finding is comparable to Thomas et al.'s (2002) qualitative exploration of patients experiences of a psychiatric inpatient environment. In their study participants described the "peer administered therapy" in the smoking as the most helpful aspect of their hospitalization (Thomas et al. p104). Similar to a smoke room, the current study attributed the negotiable boundaries of the WTGs as the reason for this versatility. Being able to negotiate the physical boundaries of the group was viewed most favourably as this allowed participants to leave the group when they wished.

An interesting finding was that participants also highlighted the benefits of establishing boundaries within their WTG, with this being viewed as necessary at times. Participants appeared receptive to boundaries when they had discussed and agreed upon these with staff and other patients beforehand. The negative impact of boundaries that were not agreed upon was highlighted by one participant. He described being confused by this boundary (i.e. a sign on the door) as it did not appear to serve any purpose and might deter other people from attending the WTG. Being treated as an equal in the decision making process appeared to be important for participants.

Finally, the freedom to explore the continuum of social interaction within the WTG was relevant for all participants. Although participants also attributed this freedom to the unstructured nature of the group, it appeared to sit alone as a sub-theme as it captured the challenges associated with this within a high security hospital. Engaging in an open manner did not come naturally for some participants, with initial reluctance about this being expressed. One participant described his concern that there would be repercussions for speaking freely; while another participants described difficulty in moving away from interpersonal structures he had become accustomed to (i.e. therapies). Interestingly, this

participant reflected on his realisation that his WTG was not restricted to one topic, with it being possible to "*talk about anything*". It is reasonable to suggest this may be a reflection of the restricted scope of conversation within structured group interventions. However, this might also highlight the degree to which social interaction feels restricted for some patients more generally.

An interesting finding was the importance participants placed on being able to express negative feelings within their WTG. Participants reflected on the acceptance of this type of interaction within the group, with the suggestion these would not be shared and/or accepted in other settings. One participant described a purposeful disagreement with staff with the purpose of getting to know more about them. Given previous research has demonstrated that patients within secure forensic setting are less likely to share a side of themselves that could be associated with risk status (Reynolds et al, 2014), participants engaging in this behaviour within the group suggests some participants experience their WTG as a permissive environment, one of the therapeutic components the WTG is based upon (Perry, 2012).

4.5.2.3. Facing something new

The process involved when facing the WTG for the first time was salient for the majority of participants. Some patients were open-minded about the idea of something new, while other participants were ambivalent about attending their WTG. These differing perspectives can be understood within the context of Prochaska & DiClemente's Transtheoretical Model (TTM) (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992). Research has demonstrated that individuals move through stages of change when modifying their behaviour. The time that can be spent in each stage varies but the tasks required at each stage do not. Certain processes are helpful at each stage to reduce resistance and facilitate progress (i.e. decisional balance, self-efficacy and processes of change). TTM suggests there are 6

stages of change, these being Precontemplation (not ready), Contemplation (getting ready), Preparation (Ready), Action, Maintenance and Termination. Being aware of where an individual is currently placed within this model is beneficial as action-oriented guidance can be detrimental for individuals in the earlier stages of the model. Therefore guidance related to an individual's current stage can encourage increased participation in the change process. This is a positive finding as it suggests all patients are somewhere within the model, giving continued scope to aid their progress through each stage (Prochaska & Velicer, 1997).

Irrespective of their position, there was a sense that participants were not clear on what the WTGs entailed. While the open-minded participants were content to go along to the group and find out more; the ambivalent participants had various reasons to delay their attendance. Some made assumptions about what their WTG was about. These assumptions were largely negative and appeared to be related to their past experiences of group settings within the hospital. Other participants appeared concerned about the open nature of their WTG as they did not know what would be discussed or what they would be expected to talk about. Two participants expressed their suspicions about the WTG being "sold" as one thing but other elements being introduced in an adhoc fashion (i.e. taking notes), while this suspicion is partly associated with what staff are writing about participants, it appears to be the perception of this being kept from them that participants are most concerned about.

Previous research suggests that patients within secure services prefer activities to be planned, with Long et al.'s (2012) qualitative exploration found that patients viewed a shared understanding of boundaries as a key characteristic of an effective therapeutic milieu. Using the Ward Atmosphere Scale, the most widely used tool for capturing aspects of the treatment environment (Moos, 1997), several studies have demonstrated the association between order and organization and patient satisfaction on wards for patients with psychosis (Friis, 1986; Rossberg & Friis, 2003; Rossberg & Friis, 2004). Given that activities within a high secure

hospital are generally well defined with clear boundaries, some participants initial ambivalence towards attending their WTG might have been associated with a lack of understanding around these aspects of the group. Therefore, while participants enjoy the versatility afforded by negotiable boundaries, it appears to be important that prior knowledge of the parameters of activities are known, particularly when facing new endeavours such as the WTG.

4.5.2.4. The institution

Although it did not emerge as a prominent theme, several aspects of participants' interviews suggest difficulties with trust of staff. These concerned suspicion around note taking about groups, lack of clarity around the purpose of the groups and unclear boundaries around what could be discussed outside of groups. Although it is beyond the scope of this study, the researcher has also noted in her clinical experience, some barriers to acceptance and understanding of the WTGs from a minority of staff members. From discussion with colleagues, this appears to be related to staff interpreting these groups as invading their territory with an intervention they believe they are already offering (i.e. talking to patients). The potential relevance of issues such as these can be understood within the context of attachment theory. Studies have found higher levels of insecure attachment styles in people with psychosis (Couture, Lecomte & Leclerc, 2007; Ponizovsky, Nechamkin & Rosca, 2007). This is also the case within forensic services, where the prevalence of personality disorder diagnoses is 60%-80%, significantly higher than community prevalence of 4% (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006; Duggan & Howard, 2009). As most forensic patients have histories of abuse perpetrated by caregivers, they are understandably suspicious of authority figures and/or people who claim to be caregivers (Adshead & Aiyegbusi, 2014). An awareness of these attachment issues can help staff to act as a 'secure base' for therapeutic

engagement; reducing the opportunity for the internal working models (IWMs) patients have of carers to be activated.

However, it would be reasonable to conclude the difficulties raised by participants suggest current practice within WTGs, however unintentional and/or perpetuated by negative staff attitudes towards these groups, have the potential to activate these IWMs. The attachment relationship between staff and patients is important in healthcare, particularly in places where staff and patients engage in long-term relationships. Professionals working within forensic services will themselves have IWMs of relationships, with recent data from non-clinical samples suggesting insecure attachment patterns will be found in as much as 40% of the workforce (Bakermans-Kranenburg & Van IJzendoorn, 2009; Adshead, 2010). Therapist attachment style has been shown to influence therapeutic relationships in forensic care (Zegers, Schuengel, van IJzendoorn, & Janssens, 2006). This can lead staff with insecure attachments to inadvertently react in unhelpful ways (e.g. agitated, hostile, avoidant) when faced with threat or need. Two different enquiries into failure of institutional care at Ashworth (Department of Health, 1990; Fallon Report, 1990) are examples of the detrimental impact of highly disorganised attachment relationships between staff and patients. Although these are extreme examples, they effectively highlight the challenge inherent when working within long-term forensic services. It is therefore important that forensic services have these challenges at the forefront of their minds and consider these issues as a routine part of their clinical practice (Adshead & Aiyegbusi, 2014).

4.5.3. Strengths and limitations of the study

The use of a qualitative methodology is considered a strength as it provided an opportunity to explore patients perceptions of a novel therapeutic intervention. Previous research has shown that staff and patients perceptions of ward environments can vary greatly, it was therefore

considered important that patients' voices were heard with regards to their experiences of WTGs. However, it is important to acknowledge that the three main themes identified within this study are only one interpretation of the data (Jordan, Eccleston, & Osborn, 2007). While independent reviews of some of the transcripts by the second and third authors allowed for consideration of alternative perspectives of the analysis. There was little scope to explore more or all of the analysis in this way and limited opportunity to obtain participants' views on the study findings. These are considered limitations of the current study. This degree of triangulation of data would have allowed for further validation of the study findings, adding credibility to these (Tong, Sainsbury, & Craig, 2007). It was also necessary to use purposive sampling as participants were required to have attended their WTG. It is therefore recognised that participants that viewed their WTGs more favourably were more likely to agree to participate in the study, introducing the potential for bias.

A further limitation of this study was the possible heterogeneity within the sample. The participants recruited were members of different WTGs, based on different wards of the hospital. Although WTGs are run according to predefined guidelines, the unstructured nature of these groups and the influence of the ward atmosphere on each respective ward, does not allow us to know the inherent differences in these groups and the resulting impact this might have on participants' experiences of them. However, although findings were presented for the group as a whole, specific nuances within the data were also explored; with these being grounded within participant transcripts. Recruitment from one WTG was considered during the early stages of study design; however this approach was considered unlikely to recruit sufficient participant numbers.

4.5.4. Implications and Future Research

The current study illustrated the deficit in staff-patient relationships identified in previous literature. The findings suggest the dual role occupied by staff and characteristics specific to patients within this setting, might make it more difficult to form relationships with others. However, the WTG appears to provide a space whereby some of these obstacles can be overcome. The findings suggest the WTG assists patients to develop a more well-rounded sense of themselves and others by sharing the positive aspects of themselves, rather than the limited side of themselves generally displayed and/or perceived within these settings.

This appears to be achieved in different ways within the WTG. Sharing experiences appeared to be viewed as cathartic, with the group also providing a place where participants can experience staff as fully attending to them. While staff are not necessarily viewed as members of the group in the same way as patients, they are viewed as having a role to play in maintaining equality among peers. This suggests the dual role often viewed as detrimental to establishing meaningful relationships can be viewed positively when its function is perceived as supportive. This was also apparent in participants' descriptions of boundaries within their WTG, with patients being more receptive when they were involved in the decision making process prior to the establishment of boundaries. However, the importance of information was highlighted by participants. While participants enjoy the versatility of negotiable boundaries, they initially prefer to know the parameters of these with these being well defined prior to engaging in new activities like the WTG.

The findings also suggest that patient characteristics, as well as detention within high security care, might influence patients perceptions of choice. Given a large majority of patients are transferred from prison, there is a high likelihood that a social hierarchy functions within patient wards. It is therefore important that staff members are aware of the history of group members as this social hierarchy is likely to influence group dynamics. Also, there

appears to be some difficulties associated with the concept of a voluntary group within a high security hospital. It was clear from participants comments that choice within the confines of the hospital is intrinsically linked to how their decisions would influence their progress through the system. Unfortunately the reality of these settings is that patients will engage in behaviour they believe will place them in a favourable light. It is therefore important that patients' understanding about the purpose of the WTGs is clear from the outset to ensure they do not feel coerced into attendance.

There are some recommendations for future research in light of this study's findings. As stated previously, the WTGs were based on the evidence base for TCs. However, as they have been explicitly removed from many of the elements of TCs, the WTGs effectiveness might not actually be clearly related to the TC literature. Further research seeking to establish why the WTGs are effective (i.e. what group and institutional processes might be operating) would be of benefit. A further qualitative exploration of staff' perceptions of WTGs would provide more information about how they perceive the groups and whether their experiences are comparable to findings in the current study. It would also be beneficial to formally explore possible negative attitudes towards the WTGs to establish why this is the case. Further exploration of the views of patients who do not attend the WTG is also needed as this would provide some insight into the reasons for this and whether changes to the WTG require to be made in order to accommodate these patients.

4.5.5. Conclusions

This study has taken a step towards evaluating patients experiences of a novel therapeutic intervention designed within a high security hospital. Allowing participants' voices to be heard by discussing their perspectives, opinions, thoughts and feelings about their WTG has enriched understanding of these groups from the perspectives of patients. It has provided new

insights into the complex interaction between security and care, with the WTGs perhaps beginning to bridge the gap between these seemingly opposing concepts. It is hoped the findings of this study will increase awareness around the function of WTGs and better inform the development of a therapeutic environment within the hospital.

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6. Appendices

6.1. Appendix A - International Journal of Forensic Mental Health Author Guidelines

(Abridged author guidelines and formatting adjusted to assist with presentation)

Manuscript. *International Journal of Forensic Mental Health* receives all manuscript submissions electronically via their ScholarOne Manuscripts website located at: <http://mc.manuscriptcentral.com/UFMH>. ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, as well as facilitating the review process and internal communication between authors, editors and reviewers via a web-based platform. For ScholarOne Manuscripts technical support, you may contact them by e-mail or phone support via <http://scholarone.com/services/support/>. If you have any other requests please contact the journal at rosenfeld@fordham.edu.

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All parts of the manuscript should be typewritten, double spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of not more than 100 words. Avoid abbreviations, diagrams, and reference to the text in the abstract. Each author should be listed with his or her primary departmental affiliation and institution name, and city/state/country (where applicable).

References. References, citations, and general style of manuscripts should be prepared in accordance with the APA Publication Manual, 6th ed. Cite in the text by author and date (Smith, 1983) and include an alphabetical list at the end of the article. *Examples: Journal:* Tsai, M., & Wagner, N.N. (1978). Therapy groups for women sexually molested as children. *Archives of Sexual Behaviour*, 7(6), 417-427. doi: 10.1037/0096-3445.134.2.258

Book: Millman, M. (1980). *Such a pretty face*. New York: W.W. Norton.

Contribution to a Book: Hartley, J.T., & Walsh, D.A. (1980). Contemporary issues in adult development of learning. In I.W. Poon (ed.). *Ageing in the 1980s* (pp. 239-252). Washington, DC: American Psychological Association.

Illustrations. Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

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6.2. Appendix B- Table of Excluded Studies

Aho-Mustonen, Miettinen, Koivisto, Timonen and Raty (2008)	Did not measure psychotic symptoms
Bickerdike and Matias (2011)	Descriptive paper
Clark, Cullen, Walwyn and Fahy (2010)	Did not measure psychotic symptoms
Cullen, Clarke, Kuipers, Hodgins, Dean and Fahy (2012)	Did not measure psychotic symptoms
Garrett and Lerman (2007)	Descriptive paper
Haddock, Barrowclough, Shaw, Dunn and Novaco (2009)	Included non-forensic participants
Hall and Long (2009)	Did not measure psychotic symptoms
Hodel and West (2003)	Did not measure psychotic symptoms
Hornsveld and Kavelaars (2000)	Not in English
Jennings, Harris, Gregoire, Merrin, Peyton and Bray (2002)	Did not measure psychotic symptoms
Jonavska, Jengic, Safner, Boskovic and Zudenigo (2011)	Only abstract available - no author contact details
McInnes, Sellwood and Jones (2006)	Did not measure psychotic symptoms
Savage (2007)	Focus is on identification of early warning signs of relapse
Vukasovic (2012)	Only abstract available - no author contact details
Yip, Gudjonsson, Perkins, Doidge, Hopkin and Young (2013)	Did not measure psychotic symptoms

6.3. Appendix C - Notes on table 3.1

KASQ = Knowledge about Schizophrenia Questionnaire (Ascher-Svanum & Krause, 1991)

SUMD = Scale to Assess Unawareness of Mental Disorder (Amador, Flaum, Andreasen, Strauss, Yale, Clark, & Gorman, 1994)

CRS = Compliance Rating Scale (Kemp & David, 1996)

BPRS = The Brief Psychiatric Rating Scale (Overall & Gorham, 1962)

NOSIE-30 = The Nurses' Observation Scale for Inpatient Evaluation (Honigfeld, Roderic & Klett, 1966)

Finnish version of the BDI-II = Finnish version of the Beck Depression Inventory: Second Edition (Beck, Steer & Brown, 1996; Psykologien Kustannus, 2004)

RSE = Rosenberg Self-Esteem Scale (Rosenberg, 1965); 15D (Sintonen, 2001)

PSQ = Perceived Stigma Questionnaire (Link, Cullen & Struening, 1989)

PANAS = Positive and Negative Affect Scale (Watson, Clark & Tellegen, 1988)

SWLS = Satisfaction with Life Scale (Diener, Emmons, Larsen & Griffen, 1985)

FTT = Future Thinking Task (MacLoed, Rose & Williams, 1993)

HADS = Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983)

BHS = Beck Hopelessness Scale (Beck, Weissman, Lester & Trexler, 1974)

NSS = Negative Syndrome Scale (Kay, Fiszbein & Opler, 1987)

REHAB = Rehabilitation Evaluation Hall and Baker (Baker & Hall, 1988; Van der Gaag & Wilken, 1994)

MI Observation scale = Meijers Institute Observation Scale (Brand, Diks, van Emmerik & Raes, 1988)

PANSS = Positive and Negative Syndrome Scale (Kay, Fiszbein & Opler, 1987)

SIG = Schaal voor Interpersoonlijk Gedrag (Questionnaire for Interpersonal Behaviour) (Arrindell, Groot & Walburg, 1984)

RSCQ = Robson Self-Concept Questionnaire (Robson, 1989)

SIP = Self-Image Profile for Adults (Butler & Gasson, 2004)

PSYRATS = Psychotic Symptom Rating Scales (Haddock, McCarron, Tarrier & Faragher, 1999)

BDI-II = Beck Depression Inventory: Second Edition (Beck, Steer & Brown, 1996)

GAF = Global Assessment of Functioning Scale (DSM-IV-TR, 2000)

MacCAT-T = The MacArthur Competence Assessment Tool- Treatment (Grisso & Appelbaum, 1995; Grisson, Appelbaum & Hill-Fotouhi, 1997)

MacCAT-FP = MacArthur Competence Assessment Tool-Fitness to Plead (Akinkunmi, 2002; Hope, Bonnie, Poythress, Monahan, Eisenberg, & Fecht-Havier, 1997)

DUNDRUM-1 (Flynn, O'Neill & Kennedy, 2011; Kennedy, O'Neill, Flynn & Gill, 2010)

HCR-20 (Webster, Douglas, Eaves & Hart, 1997)

UMQ = Understanding of Medication Questionnaire (MacPherson, Jerron & Hughes, 1996)
SAI = Schedule for Assessment of Insight (David, 1990)
FAKT = Forensic Assessment of Knowledge Tool (Walker, Connaughton, Wilson & Martin, 2012)
CDSS = Calgary Depression Scale for Schizophrenia (Addington & Addington, 1993)
SQLS-R4 = Schizophrenia Quality of Life Scale Revision 4 (Martin & Allan, 2007)
BEST Index = Behaviour Status Index (Woods, Reed & Robinson, 1999);
SAPS = Scale for the Assessment of Positive Symptoms (Andreasen, 1984a);
SANS = Scale for the Assessment of Negative Symptoms (Andreasen, 1984b);
DASS = Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995);
IIP = Inventory of Interpersonal Problems (Harowitz, Rosenberg, Baer, Ureno & Villasenor, 1988)

6.4. Appendix D - Quality Assessment Materials

Quality Assessment Tool

Study Design and potential bias

1. Participants were randomly allocated with this process being sufficiently concealed:

Well covered (3)	The method of allocation and concealment are clearly described.
Adequately addressed (2)	The method of allocation and concealment are mentioned but are not described in sufficient enough detail to be clear.
Poorly addressed (1)	The method of allocation or concealment are mentioned but are not sufficiently described. Alternatively, allocation in non-randomised.
Not addressed (0)	The method of allocation and/or concealment is not addressed.
Not reported (0)	The method of allocation and/or concealment is not reported.
Not applicable (0)	The method of allocation and/or concealment is not applicable in this study.

2. An independent concealment of allocation procedure is used:

Well covered (3)	Those administering the outcome measures were blind to the allocation of participants. Alternatively, different people administered the measures and delivered the intervention. The method of this being ensured is clearly described.
Adequately addressed (2)	The method of how researchers were blinded to allocation is described but is not sufficiently detailed in order to fully understand the method by which this was ensured.
Poorly addressed (q)	The blinding of researchers is mentioned but the method is not described.
Not addressed (0)	The blinding of researchers was not discussed.
Not reported (0)	The blinding of researchers was not reported.
Not applicable (0)	The blinding of researchers is not applicable to this study.

3. Acceptable and comparable attrition rates between groups.

Well covered (3)	Details are given regarding the drop out rates for both groups. These are similar for each group (from pre- post intervention within 10% of each other and 20% of total participants).
Adequately addressed (2)	Details are given regarding the drop out rates for both groups. These rates are somewhat alike between groups (within 20% of each other and less than 30% of total participants from pre- to post-intervention).
Poorly addressed (1)	Details are given regarding the drop out rates for both groups. There are high drop out rates in general or uneven drop out rates.
Not addressed (0)	Dropout rates are mentioned but not clearly described.
Not reported (0)	Dropout rates are not reported.
Not applicable (0)	Dropout rates are not applicable in this study.

4. Follow-up assessment at a suitable time period completed.

Well covered (3)	Described sufficiently well to determine that follow-up period after the intervention is reasonable. At least 6 months post end of intervention . Follow-up data must include outcome measures used at baseline.
Adequately addressed (2)	Described sufficiently well to determine that follow-up period after the intervention is adequate. At least 3-6 months post end of intervention . Follow-up data must include outcome measures used at baseline.
Poorly addressed (1)	Described sufficiently well to determine that follow-up period after the intervention is inadequate. Follow up less than 3 months post end of intervention . Follow-up data must include outcome measures used at baseline.
Not addressed (0)	Follow-up is mentioned but is not described in sufficient detail to determine time period.
Not reported (0)	Follow-up assessment not reported.
Not applicable (0)	Follow-up assessment not applicable in this study.

Outcomes

5. Outcome measures for psychotic symptoms are evidenced to be both valid and reliable and psychometric values are specified by the authors.

Well covered (3)	Outcome measures are used with their psychometric properties being well reported. Details of their validity and reliability within a forensic psychiatric population are also reported.
Adequately addressed (2)	Outcome measures are used with their psychometric properties being reported less well. Details of their validity and reliability within a forensic psychiatric population are less clear.
Poorly addressed (1)	The use of outcome measures is mentioned but with little information given about the measures or their psychometric properties.
Not addressed (0)	The use of outcome measures is mentioned but no further information is provided.
Not reported (0)	The use of outcome measures are not reported.
Not applicable (0)	The use of outcome measures are not applicable in this study.

6. The outcome is relevant and meaningful to the intervention:

Well covered (3)	The outcome is described and is relevant to both the intervention and the evaluation of this within the context of psychotic symptom reduction in forensic patients.
Adequately addressed (2)	The outcome is described but is less relevant either to the specific intervention being delivered or within the context of psychotic symptom reduction in forensic patients.
Poorly addressed (1)	The outcome is mentioned but is less well covered and its usefulness to the evaluation of the intervention or broader context of psychotic symptom reduction in forensic patients is less clearly described.
Not addressed (0)	The overall outcome is not related to the intervention specifically or the broader context of psychotic symptom reduction in forensic

	patients.
Not reported (0)	How the outcome is related to the intervention and evaluation is not reported.
Not applicable (0)	How the outcome is related to the intervention and evaluation is not applicable in this study.

7. Study is adequately powered to detect the effect of the intervention:

Well covered (3)	A power calculation was completed using a reasonable effect size estimation and is clearly reported along with sufficient sample size within each group.
Adequately addressed (2)	A power calculation is carried out, however, arbitrary effect size estimation used.
Poorly addressed (1)	Power calculation is completed, however, effect size estimation not mentioned and no evidence of this having informed the sample size in each group.
Not addressed (0)	Power calculation not completed or paper failed to meet the power calculation with sufficient sample size meaning any difference is not statistically significant.
Not reported (0)	Power calculation not reported.
Not applicable (0)	Power calculation not applicable in this instance.

8. Appropriate analysis for outcome measures used and p values, confidence intervals and effect sizes reported where appropriate:

Well covered (3)	Method of quantitative analysis used provides meaningful results of outcome and the confidence intervals, p-values and effect sizes are reported where appropriate. The analysis is described in sufficient detail so as statistical significance as well as descriptive information is clearly presented.
Adequately addressed (2)	The quantitative analysis used provides meaningful results, however, the details of this such as the p-values, confidence intervals and effect sizes are less well covered.
Poorly addressed (1)	The method of analysis used has not been well considered and does not provide the best presentation of results from the study. The p values, effect sizes and confidence intervals may have mentioned but are not sufficient in this case.
Not addressed (0)	There has not been any quantitative analysis used in this case, rather inconclusive findings have been provided.
Not reported (0)	The methods of analysis have not been reported.
Not applicable (0)	The methods of analysis are not applicable in this instance.

Quality of reporting

9. The TREND, CONSORT and STROBE statement guidelines for reporting have been adhered to in the RCT's, non-randomised trials and observational studies (*guidelines included within appendices*):

Well covered (3)	The reporting and layout of the article has strictly followed the relevant statement guideline.
Adequately addressed (2)	The layout of the article is not in exactly the same format as that provided by the relevant guideline; however, the content required by the guideline is present.
Poorly addressed (1)	The guideline of reporting has not been adhered to successfully. There is evidence that aspects of the guideline have been considered but has not been sufficiently followed.
Not addressed (0)	There is no evidence that the guideline has been considered when the article has been developed.
Not reported (0)	
Not applicable (0)	Adherence to the relevant guideline is not applicable in this study.

Quality of the intervention

10. The intervention has been appropriately defined:

Well covered (3)	The intervention is covered in sufficient detail including reference to the theoretical underpinnings and the potential impact the intervention could have on psychotic symptoms. The content and procedures of the intervention are clearly described so as it could be replicated by the reader.
Adequately addressed (2)	The intervention is described in relatively sufficient detail, although is less well covered. The theoretical underpinnings and potential impact the intervention could have on psychotic symptoms is discussed but in less detail. The content and procedures are also mentioned but lack the detail necessary for the intervention to be accurately replicated.
Poorly addressed (1)	The intervention is described; however, there is a lack of reference to the theoretical underpinnings and potential impact on psychotic symptoms. The content and procedures are not discussed.
Not addressed (0)	The aims of the intervention are mentioned but the underpinnings and procedures of the intervention are lacking.
Not reported (0)	Details of the intervention itself are not reported.
Not applicable (0)	Details of the intervention are not applicable in this study.

11. The intervention is both sufficiently defined and delivered as planned (i.e. demonstrates good fidelity):

Well covered (3)	Details of how the treatment was operationalised (e.g. treatment manual) are provided and adhered to, as are fidelity checks (e.g. supervision and/or reflective practice)
Adequately addressed (2)	Details of how the treatment was operationalised (e.g. treatment manual) are provided and adhered to but there are no fidelity checks
Poorly addressed (1)	Details of how the treatment was operationalised are given but there is no evidence of this being adhered to and/or no evidence of fidelity checks
Not addressed (0)	Operationalisation of the intervention and/or fidelity checks are mentioned but no further detail is given.
Not reported (0)	Operationalisation of the intervention and/or fidelity checks are not reported.
Not applicable (0)	Operationalisation of the intervention and/or fidelity checks are not applicable in this study.


Generalisability

12. The intervention has been implemented in a way that would be considered 'routine practice':

Well covered (3)	The intervention took place in a forensic psychiatric setting and the article discusses external validity and the relevance of the intervention to this setting.
Adequately addressed (2)	The paper describes external validity and the relevance of this intervention to a forensic psychiatric setting, however, the intervention did not take place in this setting.
Poorly addressed (1)	The paper does not discuss external validity and the intervention did not take place in a forensic psychiatric setting.
Not addressed (0)	
Not reported (0)	Neither external validity nor intervention setting was reported in the paper.
Not applicable (0)	Neither external validity nor intervention setting was applicable in this study.

TREND Statement Checklist

TREND Statement Checklist

Paper Section/ Topic	Item No	Descriptor	Reported?	
				Pg #
Title and Abstract				
Title and Abstract	1	• Information on how unit were allocated to interventions		
		• Structured abstract recommended		
		• Information on target population or study sample		
Introduction				
Background	2	• Scientific background and explanation of rationale		
		• Theories used in designing behavioral interventions		
Methods				
Participants	3	• Eligibility criteria for participants, including criteria at different levels in recruitment/sampling plan (e.g., cities, clinics, subjects)		
		• Method of recruitment (e.g., referral, self-selection), including the sampling method if a systematic sampling plan was implemented		
		• Recruitment setting		
		• Settings and locations where the data were collected		
Interventions	4	• Details of the interventions intended for each study condition and how and when they were actually administered, specifically including:		
		o Content: what was given?		
		o Delivery method: how was the content given?		
		o Unit of delivery: how were the subjects grouped during delivery?		
		o Deliverer: who delivered the intervention?		
		o Setting: where was the intervention delivered?		
		o Exposure quantity and duration: how many sessions or episodes or events were intended to be delivered? How long were they intended to last?		
		o Time span: how long was it intended to take to deliver the intervention to each unit?		
o Activities to increase compliance or adherence (e.g., incentives)				
Objectives	5	• Specific objectives and hypotheses		
Outcomes	6	• Clearly defined primary and secondary outcome measures		
		• Methods used to collect data and any methods used to enhance the quality of measurements		
		• Information on validated instruments such as psychometric and biometric properties		
Sample Size	7	• How sample size was determined and, when applicable, explanation of any interim analyses and stopping rules		
Assignment Method	8	• Unit of assignment (the unit being assigned to study condition, e.g., individual, group, community)		
		• Method used to assign units to study conditions, including details of any restriction (e.g., blocking, stratification, minimization)		
		• Inclusion of aspects employed to help minimize potential bias induced due to non-randomization (e.g., matching)		

TREND Statement Checklist

Blinding (masking)	9	<ul style="list-style-type: none">Whether or not participants, those administering the interventions, and those assessing the outcomes were blinded to study condition assignment; if so, statement regarding how the blinding was accomplished and how it was assessed.		
Unit of Analysis	10	<ul style="list-style-type: none">Description of the smallest unit that is being analyzed to assess intervention effects (e.g., individual, group, or community)		
		<ul style="list-style-type: none">If the unit of analysis differs from the unit of assignment, the analytical method used to account for this (e.g., adjusting the standard error estimates by the design effect or using multilevel analysis)		
Statistical Methods	11	<ul style="list-style-type: none">Statistical methods used to compare study groups for primary methods outcome(s), including complex methods of correlated data		
		<ul style="list-style-type: none">Statistical methods used for additional analyses, such as a subgroup analyses and adjusted analysis		
		<ul style="list-style-type: none">Methods for imputing missing data, if used		
		<ul style="list-style-type: none">Statistical software or programs used		
Results				
Participant flow	12	<ul style="list-style-type: none">Flow of participants through each stage of the study: enrollment, assignment, allocation, and intervention exposure, follow-up, analysis (a diagram is strongly recommended)		
		<ul style="list-style-type: none">Enrollment: the numbers of participants screened for eligibility, found to be eligible or not eligible, declined to be enrolled, and enrolled in the study		
		<ul style="list-style-type: none">Assignment: the numbers of participants assigned to a study condition		
		<ul style="list-style-type: none">Allocation and intervention exposure: the number of participants assigned to each study condition and the number of participants who received each intervention		
		<ul style="list-style-type: none">Follow-up: the number of participants who completed the follow-up or did not complete the follow-up (i.e., lost to follow-up), by study condition		
		<ul style="list-style-type: none">Analysis: the number of participants included in or excluded from the main analysis, by study condition		
		<ul style="list-style-type: none">Description of protocol deviations from study as planned, along with reasons		
Recruitment	13	<ul style="list-style-type: none">Dates defining the periods of recruitment and follow-up		
Baseline Data	14	<ul style="list-style-type: none">Baseline demographic and clinical characteristics of participants in each study condition		
		<ul style="list-style-type: none">Baseline characteristics for each study condition relevant to specific disease prevention research		
		<ul style="list-style-type: none">Baseline comparisons of those lost to follow-up and those retained, overall and by study condition		
		<ul style="list-style-type: none">Comparison between study population at baseline and target population of interest		
Baseline equivalence	15	<ul style="list-style-type: none">Data on study group equivalence at baseline and statistical methods used to control for baseline differences		

TREND Statement Checklist

Numbers analyzed	16	<ul style="list-style-type: none"> Number of participants (denominator) included in each analysis for each study condition, particularly when the denominators change for different outcomes; statement of the results in absolute numbers when feasible 		
		<ul style="list-style-type: none"> Indication of whether the analysis strategy was “intention to treat” or, if not, description of how non-compliers were treated in the analyses 		
Outcomes and estimation	17	<ul style="list-style-type: none"> For each primary and secondary outcome, a summary of results for each estimation study condition, and the estimated effect size and a confidence interval to indicate the precision 		
		<ul style="list-style-type: none"> Inclusion of null and negative findings 		
		<ul style="list-style-type: none"> Inclusion of results from testing pre-specified causal pathways through which the intervention was intended to operate, if any 		
Ancillary analyses	18	<ul style="list-style-type: none"> Summary of other analyses performed, including subgroup or restricted analyses, indicating which are pre-specified or exploratory 		
Adverse events	19	<ul style="list-style-type: none"> Summary of all important adverse events or unintended effects in each study condition (including summary measures, effect size estimates, and confidence intervals) 		
DISCUSSION				
Interpretation	20	<ul style="list-style-type: none"> Interpretation of the results, taking into account study hypotheses, sources of potential bias, imprecision of measures, multiplicative analyses, and other limitations or weaknesses of the study 		
		<ul style="list-style-type: none"> Discussion of results taking into account the mechanism by which the intervention was intended to work (causal pathways) or alternative mechanisms or explanations 		
		<ul style="list-style-type: none"> Discussion of the success of and barriers to implementing the intervention, fidelity of implementation 		
		<ul style="list-style-type: none"> Discussion of research, programmatic, or policy implications 		
Generalizability	21	<ul style="list-style-type: none"> Generalizability (external validity) of the trial findings, taking into account the study population, the characteristics of the intervention, length of follow-up, incentives, compliance rates, specific sites/settings involved in the study, and other contextual issues 		
Overall Evidence	22	<ul style="list-style-type: none"> General interpretation of the results in the context of current evidence and current theory 		

CONSORT 2010 Checklist



CONSORT 2010 checklist of information to include when reporting a randomised trial*

Section/Topic	Item No	Checklist item	Reported on page No
Title and abstract			
	1a	Identification as a randomised trial in the title	
	1b	Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts)	
Introduction			
Background and objectives	2a	Scientific background and explanation of rationale	
	2b	Specific objectives or hypotheses	
Methods			
Trial design	3a	Description of trial design (such as parallel, factorial) including allocation ratio	
	3b	Important changes to methods after trial commencement (such as eligibility criteria), with reasons	
Participants	4a	Eligibility criteria for participants	
	4b	Settings and locations where the data were collected	
Interventions	5	The interventions for each group with sufficient details to allow replication, including how and when they were actually administered	
Outcomes	6a	Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed	
	6b	Any changes to trial outcomes after the trial commenced, with reasons	
Sample size	7a	How sample size was determined	
	7b	When applicable, explanation of any interim analyses and stopping guidelines	
Randomisation:			
Sequence generation	8a	Method used to generate the random allocation sequence	
	8b	Type of randomisation; details of any restriction (such as blocking and block size)	
Allocation concealment mechanism	9	Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned	
Implementation	10	Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions	
Blinding	11a	If done, who was blinded after assignment to interventions (for example, participants, care providers, those	

		assessing outcomes) and how	
Statistical methods	11b	If relevant, description of the similarity of interventions	
	12a	Statistical methods used to compare groups for primary and secondary outcomes	
	12b	Methods for additional analyses, such as subgroup analyses and adjusted analyses	
Results			
Participant flow (a diagram is strongly recommended)	13a	For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome	
	13b	For each group, losses and exclusions after randomisation, together with reasons	
Recruitment	14a	Dates defining the periods of recruitment and follow-up	
	14b	Why the trial ended or was stopped	
Baseline data	15	A table showing baseline demographic and clinical characteristics for each group	
Numbers analysed	16	For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups	
Outcomes and estimation	17a	For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval)	
	17b	For binary outcomes, presentation of both absolute and relative effect sizes is recommended	
Ancillary analyses	18	Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory	
Harms	19	All important harms or unintended effects in each group (for specific guidance see CONSORT for harms)	
Discussion			
Limitations	20	Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses	
Generalisability	21	Generalisability (external validity, applicability) of the trial findings	
Interpretation	22	Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence	
Other information			
Registration	23	Registration number and name of trial registry	
Protocol	24	Where the full trial protocol can be accessed, if available	
Funding	25	Sources of funding and other support (such as supply of drugs), role of funders	

*We strongly recommend reading this statement in conjunction with the CONSORT 2010 Explanation and Elaboration for important clarifications on all the items. If relevant, we also recommend reading CONSORT extensions for cluster randomised trials, non-inferiority and equivalence trials, non-pharmacological treatments, herbal interventions, and pragmatic trials. Additional extensions are forthcoming: for those and for up to date references relevant to this checklist, see www.consort-statement.org.

STROBE Statement Checklist

STROBE Statement—checklist of items that should be included in reports of observational studies

	Item No	Recommendation
Title and abstract	1	(a) Indicate the study's design with a commonly used term in the title or the abstract (b) Provide in the abstract an informative and balanced summary of what was done and what was found
Introduction		
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported
Objectives	3	State specific objectives, including any prespecified hypotheses
Methods		
Study design	4	Present key elements of study design early in the paper
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection
Participants	6	(a) <i>Cohort study</i> —Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up <i>Case-control study</i> —Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls <i>Cross-sectional study</i> —Give the eligibility criteria, and the sources and methods of selection of participants (b) <i>Cohort study</i> —For matched studies, give matching criteria and number of exposed and unexposed <i>Case-control study</i> —For matched studies, give matching criteria and the number of controls per case
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group
Bias	9	Describe any efforts to address potential sources of bias
Study size	10	Explain how the study size was arrived at
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding (b) Describe any methods used to examine subgroups and interactions (c) Explain how missing data were addressed (d) <i>Cohort study</i> —If applicable, explain how loss to follow-up was addressed <i>Case-control study</i> —If applicable, explain how matching of cases and controls was addressed <i>Cross-sectional study</i> —If applicable, describe analytical methods taking account of sampling strategy (e) Describe any sensitivity analyses

Continued on next page

Results

Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed (b) Give reasons for non-participation at each stage (c) Consider use of a flow diagram
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders (b) Indicate number of participants with missing data for each variable of interest (c) <i>Cohort study</i> —Summarise follow-up time (eg, average and total amount)
Outcome data	15*	<i>Cohort study</i> —Report numbers of outcome events or summary measures over time <i>Case-control study</i> —Report numbers in each exposure category, or summary measures of exposure <i>Cross-sectional study</i> —Report numbers of outcome events or summary measures
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included (b) Report category boundaries when continuous variables were categorized (c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses

Discussion

Key results	18	Summarise key results with reference to study objectives
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence
Generalisability	21	Discuss the generalisability (external validity) of the study results

Other information

Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based
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6.5. Appendix E - Journal of Personality and Social Psychology Author Guidelines

(Abridged author guidelines and formatting adjusted to assist with presentation)

Journal of Personality and Social Psychology®

Editors: [Eliot R. Smith](#) and [Laura A. King](#)

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Submission

Submit manuscripts to the appropriate section editor.

Interpersonal Relations and Group Processes:

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In addition to addresses and phone numbers, please supply electronic mail addresses and fax numbers, if available, for potential use by the editorial office and later by the production office.

Replications

Although not a central part of its mission, the *Journal of Personality and Social Psychology* values replications and encourages submissions that attempt to replicate important findings previously published in social and personality psychology.

Major criteria for publication of replication papers include

- the theoretical importance of the finding being replicated
- the statistical power of the replication study or studies
- the extent to which the methodology, procedure, and materials match those of the original study
- the number and power of previous replications of the same finding
- Novelty of theoretical or empirical contribution is not a major criterion, although evidence of moderators of a finding would be a positive factor.

Preference will be given to submissions by researchers other than the authors of the original finding, that present direct rather than conceptual replications, and that include attempts to replicate more than one study of a multi-study original publication. However, papers that do not meet these criteria will be considered as well.

Submit through the Manuscript Submission Portal [to the appropriate section editor as noted above] and please note that the submission is a replication article.

Replication manuscripts will be peer-reviewed and if accepted will be published online only and will be listed in the Table of Contents in the print journal.

As in the past, papers that make a substantial novel conceptual contribution and also incorporate replications of previous findings continue to be welcome as regular submissions.

Masked Review Policy

The Attitudes and Social Cognition section and the Interpersonal Relations and Group Processes section have adopted a policy of masked review for all submissions. The cover letter should include all authors' names and institutional affiliations. The first page of text should omit this information but should include the title of the manuscript and the date it is submitted. Every effort should be made to see that the manuscript itself contains no clues to the authors' identity.

Masked reviews will be done on all submissions to the Personality Processes and Individual Differences section unless unmasked review is requested by the author. This request should be included in the submission letter.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6th edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's [Checklist for Manuscript Submission](#) before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.

If your manuscript was mask reviewed, please ensure that the final version for production includes a byline and full author note for typesetting.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit [Supplementing Your Article With Online Material](#).

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see [Supplementing Your Article With Online Material](#) for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**
Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin*, 139, 133–151.
<http://dx.doi.org/10.1037/a0028566>
- **Authored Book:**
Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach*. Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, [please see the general guidelines](#).

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- \$900 for one figure
- An additional \$600 for the second figure
- An additional \$450 for each subsequent figure

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

- [Download Permissions Alert Form \(PDF, 13KB\)](#)

Publication Policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also [APA Journals® Internet Posting Guidelines](#).

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- [Download Disclosure of Interests Form \(PDF, 38KB\)](#)

Authors of accepted manuscripts are required to transfer the copyright to APA.

- For manuscripts **not** funded by the Wellcome Trust or the Research Councils UK [Publication Rights \(Copyright Transfer\) Form \(PDF, 83KB\)](#)
- For manuscripts funded by the Wellcome Trust or the Research Councils UK [Wellcome Trust or Research Councils UK Publication Rights Form \(PDF, 34KB\)](#)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- [Download Certification of Compliance With APA Ethical Principles Form \(PDF, 26KB\)](#)

The APA Ethics Office provides the full [Ethical Principles of Psychologists and Code of Conduct](#) electronically on its website in HTML, PDF, and Word format. You may also request a copy by [emailing](#) or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611

Preparing the Manuscript for Submission

(taken from *Publication Manual of the American Psychological Association* ([6th edition](#)))

The specific requirements for submitting a manuscript differ among journals. Therefore, before submitting a manuscript, refer to the journal's website. The journal's instructions to authors will tell you (a) the journal's area of coverage, that is, what kinds of manuscripts are appropriate for that journal; (b) the current editor's name and address; and (c) instructions for manuscript preparation and submission specific to that journal, including whether the journal routinely uses masked review.

Quality of presentation. The physical appearance of a manuscript can enhance or detract from it. A well-prepared manuscript encourages editors and reviewers to view your work as professional. In contrast, mechanical flaws sometimes lead reviewers to misinterpret content. In this section, we describe the mechanical details of producing a manuscript that meets requirements for peer review and publication in a scholarly journal. Publishers will produce the typeset version of your article directly from your word-processing file, should your manuscript be accepted for publication. The instructions given in this chapter lay the groundwork for producing a usable electronic file.

Assistance in scientific writing in English. Scholars who are not experienced in scientific writing in English can be hindered in their publishing efforts by a lack of familiarity with idiomatic language usage. These individuals are urged to correct the problem by consulting with colleagues who are experienced writers in the English language. They may also wish to contact copyediting services that can help authors evaluate and correct their manuscripts. We highly recommend use of these services for those who consistently face obstacles in getting their work published.

Format. Formatting your manuscript according to the specifications described in this section enhances clarity and readability and facilitates peer reviews, copyediting, and typesetting.

Typeface. The use of a uniform typeface and font size enhances readability for the editor and allows the publisher to estimate the article length. The preferred typeface for APA publications is Times New Roman, with 12-point font size. A serif typeface, "with short light lines projecting from the top or bottom of a main stroke of a letter" (Chicago Manual of Style, 2003, p. 837), is preferred for text because it improves readability and reduces eye fatigue. (A sans serif type may be used in figures, however, to provide a clean and simple line that enhances the visual presentation.) Do not use a compressed typeface or any settings in your word-processing software that decrease the spacing between letters or words. The default settings are normally acceptable.

Special characters. Special characters are accented letters and other diacriticals, Greek letters, math signs, and symbols. Type all special characters that you can, using the special character functions of your word-processing program.

Line spacing. Double-space between all text lines of the manuscript. Double-space after every line in the title, headings, footnotes, quotations, references, and figure captions. Although you may apply triple- or quadruple-spacing in special circumstances, such as immediately before and after a displayed equation, never use single-spacing or one-and-a-half spacing except in tables or figures.

Margins. Leave uniform margins of at least 1 in. (2.54 cm) at the top, bottom, left, and right of every page. Combined with a uniform typeface and font size, uniform margins enhance readability and provide a consistent gauge for estimating article length.

Line length and alignment. The length of each typed line is a maximum of 6^{1/2} in. (16.51 cm). Do not justify lines; that is, do not use the word-processing feature that adjusts spacing between words to make all lines the same length (flush with the margins). Instead, use the flush-left style, and leave the right margin uneven, or ragged. Do not divide words at the end of a line, and do not use the hyphenation function to break words at the ends of lines. Let a line run short rather than break a word at the end of a line.

Paragraphs and indentation. Indent the first line of every paragraph and the first line of every footnote. For consistency, use the tab key, which should be set at five to seven spaces, or 1^{1/2} in. The default settings in most word-processing programs are acceptable. Type the remaining lines of the manuscript to a uniform left-hand margin. The only exceptions to these requirements are (a) the abstract, (b) block quotations, (c) titles and headings, (d) table titles and notes, and (e) figure captions.

Order of manuscript pages. Arrange the pages of the manuscript as follows:

- title page

The title page includes five elements: title, running head, author byline, institutional affiliation, and author note. Identify the title page with the page number 1. The remaining pages should be numbered consecutively, using Arabic numerals (except for artwork and figures).

The running head is an abbreviated title that is printed at the top of the pages of a manuscript or published article to identify the article for readers. The running head should be a maximum of 50 characters, counting letters, punctuation, and spaces between words. It should appear flush left in all uppercase letters at the top of the title page and all subsequent pages .

- abstract (start on separate page, numbered page 2)
- text (start on a separate page, numbered page 3)
- references (start on a separate page)
- tables (start each on a separate page)
- figures (start each on a separate page; include caption on page with figure)
- appendices (start each on a separate page)

Page numbers and running heads. After the manuscript pages are arranged in the correct order, number them consecutively, beginning with the title page. Pages occasionally are separated during the editorial process, so identify each manuscript page with the running head along with the page number. (Do not use your name to identify each page, because the name will have to be removed if the manuscript receives masked review.)

Use the automatic functions of your word-processing program to generate headers and page numbers for your file. (Do not type these manuscript page headers repeatedly in your word-processing file.)

Spelling check. Most word-processing programs have a function that checks spelling. Use it. Although an electronic spelling check cannot take the place of proofreading the article, because words spelled correctly may be used incorrectly, it will lessen the chance that typographical errors in the manuscript will make their way into print when your electronic file is used to publish the article.

Supplemental materials. If you are submitting supplemental materials with your manuscript (see section 2.13), check the journal's website to determine the preferred format. If you are submitting your manuscript to an APA journal, you will need to

- submit a separate file for each supplemental document and specify the format, naming your files consistently and including the file format in the naming convention;
- provide a title for each document, bearing in mind that the file will be viewed separately from the article and will need to be sufficiently identified to be useful for the reader;
- include a context statement for each file that specifies precisely what the document or file is intended to communicate (readers should be able to ascertain what they will find in the file from the statement, whether it contains several sentences or just a few); and
- prepare each document so it is complete—that is, tables and figures intended for supplemental material should include captions in the document just as if they were appearing in the published article.

Obtain and submit necessary permission to reproduce images (in addition to copyrighted material, keep in mind that images of human subjects require the subjects' permission; see <http://www.apa.org/journals> for more guidance on supplemental material).

Cover letter. Check the journal's website for the current editor's name and for specific instructions on submission. When submitting a manuscript for consideration, enclose a letter that includes the following elements:

- specific details about the manuscript (title, length, number of tables and figures);
- a request for masked review, if that is an option for the journal and you choose to use it;
- recommendations for potential reviewers or reviewers to avoid (optional);
- information about any previous presentation of the data (e.g., at a scientific meeting);
- information about the existence of any closely related manuscripts that have been submitted for simultaneous consideration to the same or to another journal;
- notice of any interests or activities that might be seen as influencing the research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research) ;
- verification that the treatment of subjects (human or animal) was in accordance with established ethical standards; and
- a copy of the permission granted to reproduce or adapt any copyrighted material from another source or a notice that permissions are pending. (The publisher will need copies of all granted permissions on receipt of your accepted manuscript.)

The corresponding author is responsible for ensuring that all authors are in agreement with the content of the manuscript and with the order of authorship before submitting an original or revised submission (see section 1.13) . The cover letter should assure the editor that such agreements have been reached and that the corresponding author will take responsibility for informing co-authors in a timely manner of editorial decisions, reviews received, changes made in response to editorial review, and the content of revisions. If the manuscript is accepted, all the authors will need to certify authorship.

Finally, include your telephone number, fax number, e-mail address, and mailing address for future correspondence. (See Figure 8.1 for a sample cover letter.)

Interim correspondence. While a manuscript is under consideration, be sure to inform the editor of any substantive corrections needed, any change in address, and so forth. In all correspondence, include the complete manuscript title, the authors' names, and the manuscript number (which is assigned by the editor when the manuscript is first received)

6.6. Appendix F - TSH Clinical Model's 9 principles (taken from The Clinical Model 'A Framework of Principles, 2009)

Principle	Description
1.Integration	Clinical care which includes medical, psychological, social care, education and life skills development are all essential and must be coordinated and combined in care planning that tackles the needs and risks of each patient. Integration of all three security domains - physical, procedural and relational - will be fully integrated with clinical care and enhance the opportunities available to patients.
2.Patient-Focused Care	As outlined in the National Services Framework, we will place patients and their carers at the centre of all service planning and delivery. In addition, the patient-focused approach will maximise the use of our buildings and estate and will enhance autonomy and choice and improve the quality of patients' lives.
3. Individualised Care Pathways	Each patient will have an individualised care pathway that reflects the care programme approach and begins at the pre admission assessment phase and continues to the point of discharge.
4. Positive Therapeutic Milieu	We will create positive learning and enabling environments that support personal development and skills acquisition, recovery and encourage self management. All clinical staff will use a reflective practitioner model in their day to day working lives.
5. Supporting Staff	It is recognised that working with this patient group will at times be demanding and difficult. Staff will be supported and developed to enable them to meet these challenges and a culture of learning and reflection will be recognised and embraced by clinical leaders and hospital managers.
6. Strengthen Multi Disciplinary Working	Staff will adopt new ways of working that ensure communication and joint working are maximised and they will be committed to service improvement that crosses traditional

	professional boundaries. Staff will fully understand their contributions to the new clinical model and know how they play their part in achieving the organisation's goals.
7. Violence Risk Assessment and Management	Clearly set out violence risk assessments will be developed throughout the care pathway for all patients. The risk plans will make explicit the individual's present, past and future risks and include victim safety. Clinical and security safety plans to address each component will be outlined and reviewed regularly.
8. Comprehensive Mental and Physical Health Care and Treatment	All care whether for mental disorder or physical health and well being will be delivered and reviewed through the care planning process. Staff will understand and deliver a health promotion and rehabilitative approach in their daily work with patients.
9. Clinical Governance Strengthens and Informs Care	Staff will demonstrate a commitment to adopting best practice and to share new learning that supports service improvement. The organisation will promote and deliver the research and clinical effectiveness agenda and monitor the performance of our services against agreed indicators. We will learn and develop from past events and reflect on incidents, accidents, complaints and concerns in a way that is positive and transparent.

6.7. Appendix G - Reflections on experience of conducting this research

The reflective account contains identifiable information and is therefore not included in the thesis.

6.8. Appendix H - Interview Schedule

Moving towards a Therapeutic Milieu with The State Hospital: A Qualitative Analysis of Patients' Experiences of Ward Talking Groups

Interview Schedule

Version 1

13/02/13

Opening Question:

- Can you tell me how you found out about the talking group on your ward?

Prompts

- Who told you about them?
- What were you told about them?
- What did you think these groups were for?
- Tell me a bit more about that.

Focus on first impression of the ward talking group and whether this has changed over time:

- What made you decide to attend the group?

Prompts

- What were you thinking or feeling at that time?
- Did these thoughts/feelings make you more or less likely to attend the group?
- What happened to make you decide to join the group?
- Did anything happen in the group that changed these thoughts/feelings?

- How do you think about the group now?

Prompts

- What was your initial reaction when you heard about the group?
- What is your impression of the group now?
- If opinion has changed: What has made you think differently about the group?

Insight into reasons for attending/not attending the ward talking group:

- After attending the group, what made you decide to attend/not attend the group again?

Prompts

- What was it that made you want to attend/not attend again?
- What felt negative about the group?
- What felt positive about the group?
- What were you thinking or feeling at that time?
- Tell me more about that.

Comparison to other group interventions:

- When you compare these groups to other groups you have been part of, what do you think are the main differences?

Prompts

- Describe what happens in your group.
- In what ways is the group similar to other groups?
- In what ways is the group different to other groups?
- Give me an example.
- Tell me a bit more about that.

Insight into what happens in the talking group:

- Can you tell me about the things you really like about the group?

Prompts

- Give me an example.
- What were you thinking or feeling in that situation?
- What do you like about those things?
- Tell me a bit more about that.

- Can you tell me about the things you don't like about the group?

Prompts

- Give me an example.
- What were you thinking or feeling in that situation?
- What do you not like those things?
- How do you think that could have been improved?
- Tell me a bit more about that.

Insight into perceived changes due to the talking group:

- Can you tell me about anything that has changed because you went/go to the group?

Prompts

- Give me an example.
- Tell me a bit more about that.
- In what way have these changes effected you/your life?

- Can you tell me about how the group affects the ward? (staff, patients, routines)

Prompts

- Are there any positive affects on the ward?
- Are there any negative affects on the ward?
- Give me an example.
- Tell me a bit more about that.

How the talking group could be improved:

- If you could change anything about the group, what would it be?

Prompts

1. What would make the groups better?
2. How do you think these changes could happen?
3. How would these changes make the group better?
4. Tell me a bit more about that.

6.9. Appendix I: Research Study Approvals

Confirmation of Approval from The State Hospital Research Committee

Jacqueline Geddes
Trainee Clinical Psychologist
The State Hospital

Friday the 8th of March 2013

Dear Jacqueline,

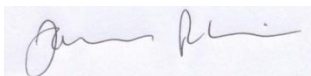
Re: Moving towards a Therapeutic Milieu with The State Hospital: A Qualitative Analysis of Patients' Experiences of Ward Talking Groups

Many thanks for your amended research proposal. The committee found the original proposal to be an interesting and valuable piece of work, and I am happy that your amended proposal has addressed the issues highlighted by the committee. I am therefore happy to approve the study. This letter will be copied to the Associate Medical Director along with evidence of your ethical approval once we have received that, and he will subsequently provide final management approval for the study to take place within TSH.

One condition of the research committees' approval is that you provide the committee with regular 6-monthly progress reports. This is an important mechanism by which the committee track progress, and is also a key component of our research governance processes. However given that the study is short in length and concern has been noted over the tight timescales I ask that you submit a progress report to the Research Committee by Monday the 20th of May for submission to the May committee meeting.

If you require any further assistance, or have any feedback on the Research approval process then please do not hesitate to contact me.

Yours sincerely



JAMIE PITCAIRN
Research & Development Manager
The StateHospital

Confirmation of Ethics Approval by the University of Edinburgh



SCHOOL of HEALTH IN SOCIAL SCIENCE
CLINICAL PSYCHOLOGY

The University of Edinburgh
Medical School
Doorway 6, Teviot Place
Edinburgh EH8 9AG

Telephone 0131 651 3969
Fax 0131 650 3891
Email submitting.ethics@ed.ac.uk

Jacqueline Geddes
3 Victoria Road
Harthill
North Lanarkshire
ML7 5QJ

04 April 2013

Dear Jacqueline,

Re: Moving Towards a Therapeutic Milieu with the State Hospital: A qualitative analysis
of patients' experiences of ward talking groups

Application for Level 2/3 Approval

Thank you for submitting the above research project for review by the Section of Clinical Psychology Ethics Research Panel. I can confirm that the submission has been independently reviewed and was approved on the 4th April 2013.

Should there be any change to the research protocol it is important that you alert us to this as this may necessitate further review.

Yours sincerely,

Kirsty Gardner
Secretary
Clinical Psychology

Confirmation from the South East Scotland Research Ethics Service that study did not require NHS ethical review

South East Scotland Research Ethics Service

Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG



Name: Jacqueline Geddes
Address: The State Hospital
Carstairs
Lanark
ML11 8RP

Date: 11/03/2013
Your Ref:
Our Ref: NR/1303AB10
Enquiries to: Alex Bailey
Direct Line: 0131 465 5679
Email: alex.bailey@nhslothian.scot.nhs.uk

Dear Jacqueline,

Project Title: Moving towards a Therapeutic Milieu with The State Hospital: A Qualitative Analysis of Patients' Experiences of Ward Talking Groups

You have sought advice from the South East Scotland Research Ethics Service on the above project. This has been considered by the Scientific Officer and you are advised that, based on the submitted documentation (email correspondence and JG_thesis_proposal_February_2013.doc), it does not need NHS ethical review under the terms of the Governance Arrangements for Research Ethics Committees (A Harmonised Edition). The advice is based on the following:

- *The project is a survey seeking the views of NHS patients on service delivery*

If the study is considered as research you may require ethical approval as outlined in The Research Governance Framework for Health and Community Care. You may wish to contact your employer or professional body to arrange this.

For studies that are not research and will be conducted within the NHS you should contact the relevant local Quality Improvement Team(s) who will inform you of the governance procedures required before the study commences.

This letter should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that NHS ethical approval is not required. However, if you, your sponsor/funder or any NHS organisation feels that the project requires ethical review by an NHS REC, please write setting out your reasons and we will be pleased to consider further. You should retain a copy of this letter with your project file as evidence that you have sought advice from the South East Scotland Research Ethics Service.

Yours sincerely,

Alex Bailey
Scientific Officer
South East Scotland Research Ethics Service



INVESTORS
IN PEOPLE



Healthy
Working
Lives

1

Headquarters
Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Chair Dr Charles J Winstanley
Chief Executive Tim Davison
Lothian NHS Board is the common name of Lothian Health Board

6.10. Appendix J - Responsible Medical Officer Consent Form

RESPONSIBLE MEDICAL OFFICER CONSENT FORM

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM



Moving towards a Therapeutic Milieu with The State Hospital: A Qualitative Analysis of Patients' Experiences of Ward Talking Groups

Please tick box

	Yes	No
1. I believe this patient is mentally well enough to take part in a semi-structured interview.	<input type="checkbox"/>	<input type="checkbox"/>
2. I consider this patient to have sufficient receptive and expressive language ability to take part in a semi-structured interview, even if additional support by the researcher would be required.	<input type="checkbox"/>	<input type="checkbox"/>
3. I agree that this patient has the capacity to consent to take part in this study.	<input type="checkbox"/>	<input type="checkbox"/>

_____ Name of Responsible Medical Officer	_____ Date	_____ Signature
_____ Name of Principal Investigator	_____ Date	_____ Signature

6.11. Appendix K - Participant Information Sheet

INFORMATION SHEET FOR PARTICIPANTS YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET



1. Study Title

Moving towards a Therapeutic Milieu with The State Hospital: A Qualitative Analysis of Patients' Experiences of Ward Talking Groups

We would like to invite you to participate in this research project. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information.

2. What is the purpose of the study?

We do not have a lot of information on patients' experiences of talking groups and this study hopes to find out more about this. This study will help us to understand the good things about talking groups but also things that could be improved. This study is also being completed as part of the principal investigator's (Jacqueline Geddes) academic work for the degree of doctorate in Clinical Psychology at the University of Edinburgh.

3. Why have I been asked to take part in this study?

You have been asked to take part in this study because you have attended your ward talking group on at least two occasions. We think you can help us with our research by sharing your experiences of being a part of these groups.

4. Do I have to take part in the study?

No, you should only participate if you want to. Choosing not to take part will not disadvantage you in any way. If you decide to take part you will be given this information sheet to keep and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

5. What will happen to me if I take part?

If you decide to take part in the study you will be asked to engage in a 60 minute interview with the principal investigator, Jacqueline Geddes. This will be arranged at a time that is convenient for you. Jacqueline will ask you questions about your experiences of being a part of the talking group. To make sure Jacqueline remembers all of your answers she will record this interview. She will then type your interview on a computer and delete this recording. When the study is completed in August 2013; you will have the opportunity to meet with Jacqueline to find out more about the findings of the study.

6. What are the possible benefits of taking part?

By taking part in this study you will help us to understand patients' experiences of being a part of the talking groups. The information you give us will let us know what patients find good about the talking groups but also things that could be improved. This information can help us improve the talking groups in the future.

7. What are the possible disadvantages of taking part?

Taking part in this study will involve reading this information leaflet and arranging a time to meet with Jacqueline to engage in an interview. However, this is only likely to last 60 minutes in total. We do not think there are any other disadvantages to taking part in this study.

8. How do I volunteer to take part in the study?

If you decide you want to take part in this study you will keep this information leaflet. Jacqueline will then contact you to arrange a time to meet to do the interview. When you meet Jacqueline she will ask you to sign a consent form. You will also be given a copy of this to keep.

9. What do I do if I decide I no longer want to take part in the study?

If you decide you no longer want to participate in the study that is ok. All you need to do is tell your keyworker and they will let Jacqueline know. We will then destroy all of the information we may have collected from you.

10. Will my information be kept confidential?

Yes, all information you give to us in the interview will be anonymised so that you cannot be identified from it. Once your interview is recorded, Jacqueline will type this up on a computer. This data will be kept on an NHS computer during the course of the study. Once the study is completed in August 2013; all of this data will be stored for six years in line with NHS policy, at which point it will be destroyed.

11. What will happen to the results of the study?

The results of this study may be presented at conferences and published in a journal. They will also be written up and submitted as part of Jacqueline's academic work for her degree of doctorate in Clinical Psychology.

For more information about the study ask your keyworker to contact:

Jacqueline Geddes
Trainee Clinical Psychologist
Iona Hub

Jacqueline will arrange a time to meet with you.

Thank you for taking the time to read this information sheet.

6.12. Appendix L - Participant Consent Form

CONSENT FORM



YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM

Moving towards a Therapeutic Milieu with The State Hospital: A Qualitative Analysis of Patients' Experiences of Ward Talking Groups

Please tick box

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I agree to the interview being audio-recorded. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I agree to the use of anonymised quotes in publications. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I agree that my data gathered in this study will be stored by the NHS for 6 years, at which point it will be destroyed. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. I agree to take part in the above study. | <input type="checkbox"/> | <input type="checkbox"/> |

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Principal Investigator	Date	Signature

6.13. Appendix M - Sample of Analysis

Left column: Transcript

Middle column = initial noting

Right column = developing emerging themes

Normal text = Descriptive comments; *Italics* = Linguistic comments; Underlined text = Conceptual and interpretative comments; (Bracketed comments = Free association)

Original transcript	Exploratory comments	Emergent Themes
<p>Opening Question: I: Can you tell me how you found out about the talking group on your ward?</p> <p>A: A notice was put up on the notice board in the ward...that was the first thing I saw.</p> <p>I: Who told you about them?</p> <p>A: X came and basically told us that it was voluntary and we didn't have to go if we didn't want to and that it would be relaxed subjects that we wanted to speak about.</p>	<p>How he found out about the talking group. <u>Groups are a novel concept, is a notice informative enough? Would he have found out about the groups if he hadn't seen the notice? Pause might suggest an absence of further information/knowledge about the groups at that time.</u></p> <p>Learning the groups were voluntary and topics would be things patients wanted to speak about. Is <i>there a suggestion that at other times patient feels forced to speak about things they don't want to "didn't have to if we didn't want to"</i>. <u>How does this perception (reality?) impact on their ability to engage meaningfully with others more generally?</u></p>	<p><u>(Initial Lack of information/understanding about group?)</u></p> <p><u>Finding out be accident?</u></p> <p><u>(Novelty of choice?)</u></p> <p><u>Groups are voluntary</u></p>

Original transcript	Exploratory comments	Emergent Themes
<p>I: What did you think these groups were for?</p> <p>I thought it would be a complaints group and I wasn't sure if I wanted to go and sit down and listen to people's moans but when I went we spoke about everything and anything. It was a lot more relaxed and everyone was speaking about their own experiences. We used to have ward meetings in the old hospital once a month and it was normally about 40 minutes of people complaining so this was better. I thought it would be the same but it wasn't.</p> <p>Focus on first impression of the ward talking group and whether this has changed over time:</p> <p>I: What made you decide to attend the group?</p> <p>A: I had about 20 minutes before I went to my placement at Arts and Crafts so I thought I would go in for 20 minutes and I was surprised and when Arts and Crafts did phone for me, I thought about staying, it wasn't a big deal leaving the group while it was on. In the past, at the monthly meeting in the old hospital, you would normally have to wait until you were finished the meeting before you could go.</p>	<p><i>The use of words like complain/moan might suggest an underlying theme of patients being generally unhappy, leading to the assumption that a talking group would be a forum to complain. Use of language "everything and anything, a lot more", highlights these groups being different to what has come before and realising this, "I thought...but it wasn't". <u>If this assumption is true, is a notice the best way to inform patients of new processes? Does there need to be a willingness for things to be different in order to engage in the group? What happens if that isn't there? Is there a particular type of patient that can/cannot engage in this process?</u></i></p> <p>Testing the group.</p> <p><i>Language emphasises surprise and uncertainty around flexibility of boundaries of group "it wasn't a big deal leaving"; "you would normally have to wait", "I thought about staying". <u>Appears to be an awareness that experience was enjoyable and an uncertainty around this. There also seems to be a resistance to change despite considering this.</u></i></p> <p>(The patient appears more confident than other peers. Would other peers be confident enough to test out the flexible boundaries in the beginning? I wonder if some patients feel they</p>	<p><u>Previous experience shaping current understanding of groups</u></p> <p><u>Hearing other people's experiences</u></p> <p><u>Freedom within conversation</u></p> <p><u>Surprise group was enjoyable</u></p> <p><u>Recognition that boundaries were more strict in the past</u></p> <p><u>(Importance of willingness to try</u></p>

<p>I: What were you thinking or feeling at that time?</p> <p>A: Well, I knew X really well and they were talking about different things on TV and we were all joining in talking about what we have watched and it was really laid back. It was nice just to have normal conversations with the staff. Normally when you go to a group with the staff like X doing Drug & Alcohol, its different, we had the meeting in the dining room and had a cup of tea and said that you used to be warning me about Drug and Alcohol and now you are trying to entice me in with caffeine. We had a laugh about it, it's so relaxed and you can have a laugh about things.</p> <p>I: Did these thoughts/feelings make you more or less likely to attend the group?</p> <p>A: Definitely because it was informal and there weren't any boundaries or anything, you could talk about what you wanted, no matter how trivial, you can talk about what you want.</p>	<p>have to be in or out, there is no in-between. This is likely to lead to some patients that have never attended the group as they are not willing to sacrifice their time for something they do not understand.)</p> <p>(Emphasis on flexibility - not common generally. Is there a need to give patients opportunity to explore boundaries?)</p> <p>The normality of the group made it easier.</p> <p><i>Underlying theme of experience being something that could once have been described as social norms but "normal" being something different now. Use of language "it was nice to have normal conversation with the staff", "normally", "laugh about things".</i> <u>Deviation from the identified 'norms' in TSH appears to make it easier for this patient to engage. Is the group recreating the social norms acceptable in the community?</u></p> <p>(Enjoying this type of interaction, particularly with staff. The significance of normal conversations with staff known to him. Humour as a social lubricant.</p> <p>Does the group introduce social component that have been lost within TSH? How do we know when someone is crossing boundaries and is this ok? Should patients be encouraged to test these and establish their own boundaries?)</p> <p><i>Emphasis around freedom of speech, "informal". "weren't any boundaries", "what you wanted". Repetition of "what you want" emphasises the novelty and importance of this for the participant. Who decides what is trivial? Is there a sense that normal interaction is unimportant/not prioritised? Patients thoughts/opinions not valued? (Talking about "what you want" seems to be novel. Why is that? Do patients feel they can't talk</i></p>	<p><u>new things)</u></p> <p><u>Familiarity and humour made conversations feel 'normal'</u></p> <p><i>(Viewing staff as 'normal').)</i></p> <p><u>Freedom of speech being possible</u></p>
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<p>I: What happened to make you decide to join the group?</p> <p>A: Walking up to Arts and Crafts, I was thinking – I enjoyed that and thought it was really good, I asked a few guys on the ward when I went back how did the group go and they said it was good. It wasn't like anything any of us had done before; it was a lot more relaxed and laid back.</p> <p>I: Did anything happen in the group that changed initial thoughts about the group?</p> <p>A: It was just so open, if you had any problems or anything you wanted to say then you could just say it and have your questions answered. What would normally be the case, you would be a lot more formal.</p> <p>I: What did you think it was that made it a lot easier to ask questions?</p> <p>A: We were all just sitting together around a dining table, having a cup of tea and a chat, which is something that we never do.</p>	<p>about what they want at other times?)</p> <p>Group a novel enjoyable experience in TSH.</p> <p><i>Use of language "I asked", "they said", emphasise importance of peer opinion. <u>Would a negative opinion influence attitude towards group in a similar way? Would some peers be more influenced by peer opinion than others?</u></i></p> <p>(Time to reflect on the group and discuss it with others seems important. Wonder how easily swayed some patients are by others opinions? Learning/being aware of the hierarchy already established with ward/hospital may be important factor in group attendance/non-attendance).</p> <p>An informal place to gain information, a place to have your anxieties/worries relieved?</p> <p><i>Use of language "just so", emphasising experience of things not being open in other forums? <u>What is it about the group that makes it easier to be open?</u></i></p> <p>(Being able to discuss problems sounds like a lot more work out</p>	<p><u>as there are no boundaries around conversation</u></p> <p><i><u>(Novel experience)</u></i> <i><u>Sharing a new experience</u></i> <i><u>Reflection that group more relaxed than anything gone before</u></i></p> <p><i><u>Seeking out peer opinion about the group</u></i></p> <p><i>(Time for reflection)</i></p>
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<p>I: How do you think about the group now?</p> <p>A: I am quite happy to go and have a chat. If anyone brings things up you can give them your point of view as well. Stuff like the PARS being shut regularly and things like that, you are always there to give your point of view and agree or disagree. Any group member can change the theme or ask "what do you think?" and it's not uncomfortable. Staff can give their opinion as well, it's not just patients.</p> <p>I think the staff tend to encourage the quieter people to speak and to find out their interests and to find out if they have any problems. I think the quieter people talk more in the group than if they were not in the group because when they weren't in the group they would tend to watch TV or do something to distract them so it's good.</p> <p>I: What has made you think differently about the group?</p> <p>A: To be honest with you I haven't seen any changes in the group, it's been uniform in the way it has been, it was in the day room but there was</p>	<p>with the group. Do patients do this or do they keep problems to themselves?)</p> <p>(Discussing problems in an informal setting makes it more likely to happen).</p> <p><u>Is the set up conducive to conversation?</u></p> <p><i>The group appears to be novel as it reintroduces social norms that are largely absent, as highlighted by use of language "never do".</i></p> <p>(What makes the group work is not something new but something forgotten. Is this unique to institutions? What the group offers is not ground-breaking, just a social set up not generally offered in TSH.)</p> <p>Being able to share your point of view with others. Disagreement is not a problem. Everyone can share their opinion.)</p> <p><i>Equality in ability to communicate present within the group emphasised by using language like "give", "always", "agree or disagree", "any group member can change theme".</i></p> <p>Staff don't usually give their opinion?</p> <p><u>Staff viewed as important to group adhesion? Group conducive to peer inclusion in discussion?</u></p> <p>(A sense in this sentence that although I'm happy with what's happening just now, I wouldn't necessarily be happy with anything changing? My attendance is optional).</p>	<p><u>A place to share problems and receive support.</u></p> <p><u>Reflection that other processes are generally formal.</u></p> <p><i>(Informality conducive to sharing)</i></p> <p><i>(Reintroduction of social norms)</i></p> <p><u>Social set up makes it easier to ask questions</u></p> <p><i>(Equality between patients and staff alike)</i></p> <p><u>Freedom to express yourself.</u></p>
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<p>a few boys not wanting to take part and it wasn't as relaxed so there were people sitting with their arms crossed and the body language was saying I'm not interested in this. When we took it into the dining room it was great because we got to have a chat over a cup of tea. In a social circle outside, whether it is a pub or a café or in someone's house, you normally sit and have a drink, whether it is alcoholic or a cup of tea, you normally talk with a drink and it feels more comfortable. We weren't able to have tea in the day room because of the carpets, we started having tea and coffee in the day room when we first moved into the new hospital but there was a lot of spillage on the carpet and I think housekeeping were having to shampoo the carpets so they stopped that. To me, it's better in the dining room.</p>	<p>(Do quieter members feel safe in the group?)</p> <p>Group brings normalcy that has become unfamiliar.</p> <p><u>Clear boundaries around being in/or out makes it more comfortable as people attending want to be there.</u></p> <p><u>Addition of social norms helped process (e.g. tea/coffee). Made group more 'normal'.</u></p> <p><u>Do patients view the group as 'voluntary' when it is not boundaried?</u></p> <p>(The setting appears to be important for this participant. He values the relaxed environment absent from seemingly uninterested peers.)</p> <p>(Compares group to social interaction in the community. This is a positive comparison.)</p>	<p><u>Staff aid inclusion of quieter members</u></p> <p><u>Introducing some physical boundaries made the group more comfortable</u></p> <p><u>Having a drink makes the group more comfortable</u></p> <p><i>(Favourable comparison to the community)</i></p>
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6.14. Appendix M - Table of Recurrence of Superordinate Themes

	Interview A	Interview B	Interview C	Interview D	Interview E	Interview F	Interview G	Interview H	Interview I	Present in over half sample
Coming together as a unit	YES	YES	YES	YES	YES	YES	YES	YES	NO	YES
Liberty Vs. Control	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Facing something new	YES	YES	YES	YES	NO	YES	YES	YES	YES	YES

